National and Sector HIV/AIDS Policies in the Member States of the Southern Africa Development Community

July 2002

Prepared by the POLICY Project

Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
AZT	Zidovudine
BCC	Behaviour Change Communication
CBO	Community-based organisation
CSO	Civil society organisation
DHS	Demographic and Health Surveys
DOTS	Directly observed treatment (programmes)
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People with HIV/AIDS
HIV	Human immuno-deficiency virus
IDU	Intravenous drug user
IEC	Information, education and communication
ILO	International Labour Organisation
LAPCA	Lesotho AIDS Programme Co-ordinating Authority
MAFF	Ministry of Agriculture, Food and Fisheries (Zambia)
MCH	Maternal and child health
MTCT	Mother to child transmission
NAC	National AIDS Committee (Namibia)
NAC	National AIDS Council (Zimbabwe)
NAMACOC	National Multi-sectoral AIDS Committee (Namibia)
NGO	Non-governmental organisation
PLWHA	People living with HIV/AIDS
RAID	Rural AIDS Initiative (Malawi)
SADC	Southern Africa Development Community
SANAC	South African National AIDS Council
SAPS	South Africa Police Services
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TAC	Technical AIDS Committee

TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
USAID	U. S. Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organisation
WTO	World Trade Organisation

Preface

This report is a summary of the existing HIV/AIDS national policies and plans among countries in SADC. It is intended to provide a snapshot of the current status of policy formulation in the region and to suggest future steps to strengthen the policy environment for an effective response to the epidemic. Much of the information in this report is derived from national HIV/AIDS policies, strategic plans, HIV/AIDS policies for specific sectors and work plans. National consultants in each country collected these documents and commented on the final report. The national consultants who assisted in this work are:

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We also wish to express our thanks to the U. S. Department of State and the U. S. Agency for International Development (USAID) for funding this activity. The project was implemented by the POLICY Project, which works to facilitate the development of policies and plans that promote and sustain access to high-quality family planning and reproductive health (FP/RH) services. The project also explicitly addresses HIV/AIDS and maternal health policy issues with additional emphasis on youth, gender, and human rights; multi-sectoral policy issues; and policies that promote sustainable access to quality services.

I. Executive Summary

This paper presents a concise overview of the status of current HIV/AIDS policies among the 14 member countries of the Southern Africa Development Community (SADC). Not all countries in the region have national HIV/AIDS policies. Therefore, this review also considers policy statements contained in national strategic plans, short-term plans, and sector-specific policy and strategy statements. The review includes analysis of those existing HIV/AIDS-specific policies and programmes available from specific government line ministries. The sector-specific analysis is provided as a starting point for building an expanded multi-sectoral response to HIV/AIDS across the region. The purpose of this review is to provide SADC with a summary of the region's progress and best practices to date and recommendations for future activities that can contribute the most to improving the policy environment for an effective response to the epidemic.

A number of main themes emerge from this review. Many countries in the region have elevated HIV/AIDS to national priority status. There is broad consensus in the region that HIV is a problem impacting health as well as social and economic development. It requires a collaborative response involving a variety of stakeholders across multiple sectors and at every level, including government agencies, non-governmental organisations (NGOs), civil society organisations (including community-based groups, faith-based organisations, traditional leaders, and people living with HIV/AIDS), private businesses, international NGOs and agencies, and bi- and multi-lateral agencies. All policies reviewed promoted multi-sectoralism as a core part of their response. National responses are inclusive of provincial, district, and community-based responses that rely on local institutions and infrastructure. Generally, this approach involves the development of sector-specific HIV prevention and care policies using participatory approaches that document genuine community involvement.

There is a movement among SADC countries to uphold the human rights of people living with HIV/AIDS (PLWHA) and to formulate policies in alignment with the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, building on the framework provided in various forums, including the Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in Africa (April 2001). Many countries are already

debating how best to address the wide range of HIV-related issues: leadership; prevention, care, support and treatment; human rights; reducing vulnerability; children and youth; alleviating social and economic impact of AIDS; research and development; resource mobilisation; and so forth. In an effort to address underlying factors that promote vulnerability to HIV, quite a number of countries in Southern Africa have established policies to promote gender equality, improve women's socioeconomic status, and address violence against women.

Sector-specific policies and strategies to mount HIV control activities vary considerably in the region with respect to: the degree of HIV programming within a given line ministry; degree of integration of sector programmes in national HIV/AIDS strategies; degree of coordination to maximise impact across sectors; level of monitoring and evaluation of individual and joint programmes; method of financing multi-sectoral approaches; and which sectors play lead roles. Across the region there is still a lot of work remaining in order to build on sector-specific AIDS programmes that currently focus services solely on sector staff. There is also a need to develop consensus about core prevention and care/support practices that can then be adapted throughout each sector (i.e., for different target audiences, for different service settings) to support the governments' overall HIV/AIDS campaigns.

Significant progress has been made in the SADC region toward crafting HIV/AIDS policies that guide expansive, complex technical and ethical responses to HIV/AIDS. Yet multiple challenges face those SADC countries still grappling with development of the wide spectrum of HIV/AIDS policies and partnerships.

Comprehensive National Policies

The HIV/AIDS epidemic has reached alarming levels throughout the SADC region. All countries have organised some kind of response to this problem. Several countries have developed comprehensive national HIV/AIDS policies. These include Botswana, the Democratic Republic of Congo, Lesotho, Swaziland, Tanzania and Zimbabwe. Among those that have not developed national policies, several, including Malawi, South Africa and Zambia, are developing or considering developing such policies. Zambia just completed a national policy in 2002. A national policy is not necessarily required since specific policies can be set in plans and legislation. Zambia, for example, mounted a

vigorous AIDS programme without a comprehensive policy, but with annual reviews of specific policies and laws and the formulation of specific policies when required. However, the HIV/AIDS epidemic affects so many aspects of national, community, family and personal life that the lack of a comprehensive policy becomes more serious as the epidemic develops. A national policy also sets the framework within which sector policies can be developed.

Recommendation: Each country in the region should be encouraged to develop a comprehensive national HIV/AIDS policy.

New efforts to develop comprehensive national policies can benefit from the experience of countries that have already developed such policies. The existing policies provide good examples of the issues that need to be addressed and approaches to these issues. The process of policy development is also important. The Zimbabwe policy formulation process is a particularly good example of a participatory approach that provided great scope for involvement by all sectors of society and produced a consensus policy that was readily adopted and implemented.

National Strategic Plans

Almost all countries in the region now have HIV/AIDS strategic plans. These plans are required for a variety of purposes: to set goals and objectives for an expanded response, to describe the strategy to achieve those goals, and to estimate the funding required. Strategic plans with budgets are now also required for applications for additional funding to the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). While most of the strategic plans in the region do an excellent job of describing goals, objectives and strategies, there is wide variation in the approaches used to cost the plans. Plans that do not have well developed, reasonable budgets are less likely to be favourably received by donors and may be at a disadvantage when applications to the GFATM are reviewed.

Recommendation: SADC should work with UNAIDS to develop and disseminate sound costing approaches and ensure that national programmes have the training and assistance they need to implement these approaches.

Multi-sectoral Approaches

All countries in the region have adopted multi-sectoral approaches to HIV/AIDS prevention and care. However, these approaches vary considerably from one country to the next. In some cases, ministries other than health are encouraged to develop their own AIDS control programmes with specific staff assigned full time to AIDS, while in others ministry liaisons are assigned to coordinate activities with the Ministry of Health. Many countries have organised a National AIDS Council, located in the Office of the President. These councils are charged with organising the multi-sectoral response. In most countries, these councils are quite new and still attempting to discover the best way to coordinate the expanded response. To some people the term 'multi-sectoral approach' means involving all sectors of government, while to others it is a broader term meaning the involvement of all aspects of civil society. As countries struggle to implement these new approaches, they can learn much from each other's efforts.

Recommendation: SADC should help to promote information sharing among countries on the various approaches to organising and implementing a multi-sectoral response and on the successes and failures of such a response. This could be accomplished through comparative reports, special regional meetings, observational travel and SADC forums at international and African AIDS conferences.

Sector Initiatives

Health is the lead sector in the response to HIV/AIDS in every country in the region. Most counties involve other sectors as well. The Education sector is the involved in almost every country. The Labour and Employment sectors and the Youth/Culture/Information/Sports sector are the next most frequently involved sectors. Next come Agriculture, Tourism, Transport and Works, and Uniformed Services. Only about half the countries have active programmes involving Finance and Economic Development, Minerals and Energy, or Trade and Industry. Other sectors are even less involved.

The biggest question around sector initiatives is not so much which sectors are formally involved in the AIDS programme, but what they are doing. In some cases, ministry participation is limited to having an AIDS policy for the ministry employees while in others, the ministry is actively involved in implementing programmes to address HIV/AIDS for its constituencies (e.g., school children, prisoners, military personnel, truck drivers). Generally, within SADC only the Education and Health ministries have detailed implementation strategies to serve their constituents.

Recommendation: SADC could facilitate greater sector involvement in HIV/AIDS programmes by promoting dissemination and discussion of concrete examples of successful sector programmes both inside and outside the region.

II. Introduction

HIV/AIDS is one of the most serious development challenges in Southern Africa. In a region already facing enormous problems of poverty and political instability, its social and economic consequences are profound. Co-ordinated action, however, can limit the epidemic's spread. Nearly 20 years' experience of tackling HIV/AIDS in Africa has taught many lessons about how to approach the problem, what interventions work and how to resolve some of the difficult issues it raises. This document reviews HIV/AIDS policies in the 14 member countries of SADC: Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Its aim is to compile this experience and to provide a baseline from which to develop a consistent, region-wide policy response to HIV/AIDS.

The word 'policy' can be used to mean very different things. In this review, we use the term to refer to clear written statements of the overall, guiding principles that structure responses to a particular issue. Some countries in the region have developed comprehensive national HIV/AIDS policies. For others, policy statements are contained in strategic plans, legislation, guidelines and specific policy communications. We have reviewed all available documents to compare the stated policies of the member states. In addition, this report examines HIV/AIDS policies and plans of different sectors of government to see how extensively sectors other than health are involved in the effort to slow the AIDS epidemic.

The aim of this review is to give policy-makers a concise overview of the status of HIV/AIDS policies in the region. It is not intended to be an exhaustive enquiry into every section of every department policy that may have an impact on HIV/AIDS. Nor does it comment on how effectively these policies are implemented. Its objective is to provide policy-makers in SADC with a guide as to the region's best practices, and to suggest issues they may wish to address when developing or revising HIV/AIDS strategies.

III. National HIV/AIDS Policies

The table below presents a summary of the policies that were reviewed and the issues they addressed.

Table 1. HIV/AIDS Policies in the SADC Region

	Angola	Botswana	DR Congo	Lesotho	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Swaziland	Tanzania	Zambia	Zimbabwe
1a National policy	X	X	X						X		X	X	X	X
1b Strategic plan	X	X	X	X			X		X	X	X	X	X	X
2 National crisis/disaster	X		X						X		X	X		
3 Multisectoral approach	X	X	X	X			X	X	X	X	X	X	X	X
4 Human rights	X	X	X	X				X	X	X	X	X	X	X
4.1 PLWHA involvement	X		X	X			X		X	X		X		
4.2 Employment	X	X	X	X					X	X	X	X		X
4.3 Travel	X	X	X						X		X	X		X
4.4 Wilful transmission	X		X	X					X			X	X	X
4.5 Confidentiality	X	X	X						X			X	X	X
4.6 Insurance			X						X			X		
4.7 Prisons			X						X				X	X
4.8 Homosexuality			X											
5 Testing	X	X	X						X		X	X	X	X
6 VCT	X		X	X			X		X	X	X	X	X	X
7 IEC	X		X	X			X	X	X	X	X	X	X	X
8 Condom promotion	X		X	X				X	X	X	X	X	X	X
9 STIs	X	X	X				X		X	X	X	X	X	X
10 Safe blood	X	X	X	X	X	X	X	X	X	X	X	X	X	X
11 PMTCT	X	X	X	X					X	X		X	X	X
12 Breastfeeding	X	X	X						X			X		X
13 Care	X	X	X	X			X	X	X	X	X	X	X	X
13 Care givers	X	X	X						X	X			X	X
14 Gender	X		X	X					X	X		X	X	X
15 Youth	X		X	X					X	X	X		X	X
16 Research/surveillance	X	X	X				X		X	X	X	X	X	X
17 HIV/AIDS and poverty	X		X	X			X		X	X		X	X	X
18 Orphans	X		X	X					X	X	X	X		
19 Migrants			X						X					
20 Culture and HIV/AIDS			X	X					X	X		X		

1. A National Emergency?

Some member states have taken the step of declaring HIV/AIDS a national crisis or emergency. Different SADC countries have different levels of prevalence and the designation may not always be appropriate. However, where prevalence rates are particularly high and/or the effects of the epidemic are particularly devastating, a formal statement like this represents high-level recognition of the gravity of the situation. It may also have implications for the country's interactions with the international community. The World Trade Organisation (WTO) for example, can allow exemptions to its normal trade rules during a 'national emergency'.

Botswana, Lesotho, Swaziland and Tanzania's AIDS policies all deem HIV/AIDS a national disaster. Botswana calls it a national crisis, deserving the attention of every government and sector of society that such a crisis deserves.[1] Tanzania's national policy also calls it a national crisis, offering a compelling reason for a multi-sectoral approach.[2] In Lesotho's Policy Framework on HIV/AIDS Prevention and Management, the king and government have declared HIV/AIDS a 'disaster of national proportion deserving national priority status.' The government will 'ensure that HIV/AIDS and STI continue to remain in the public agenda by seizing every opportunity to advocate on … related issues.'[3] While the Mozambique strategic plan does not use the term 'national disaster', it states that 'the magnitude and current and future impacts of the HIV/AIDS epidemic … have reached such high levels as to imperil expected social and economic progress.' In another document, the Ministry of Health states, 'Not a place in the country is unaffected by the epidemic. Instead of speaking about "good" and "bad", we must speak of "bad" and "worse"'.[4] Swaziland's strategic plan describes AIDS problems as a matter of 'national urgency,' and cites His Majesty King Mswati III, who declared HIV/AIDS a national disaster during the opening of the seventh parliament of the Kingdom of Swaziland on February 19, 1999.

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[1] *Botswana National Policy on HIV/AIDS.* Ministry of Health. Botswana. November 1993, p. 4.
[2] *National Policy on HIV/AIDS/STD.* National AIDS Control Programme. Tanzania. September 1995, p. 26.
[3] *Policy Framework in HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 7
[4] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, p. vii. *Report of Seminar to Define the HIV/AIDS Epidemic in Mozambique.* Maputo. August 1999, p. 59.

2. Multi-sectoral Approach

HIV/AIDS is not simply a health issue, but a development problem that has profound economic, social and cultural implications. On their own, ministries of health lack the resources to cope with the growing demands of the prevention of HIV transmission and care for PLWHA. Individual and community vulnerability to HIV/AIDS is partly a function of their economic, political, legal and social resources. There is, therefore, a clear consensus within the SADC region that effective HIV/AIDS interventions require the collaboration of a range of stakeholders, including government agencies, NGOs, civil society organisations (CSOs) and businesses.

All policies reviewed promoted multi-sectoralism as a core part of their response. In most cases, this commitment is institutionalised in the form of multi-sectoral AIDS committees. In practice, however, the term 'multi-sectoralism' can be used to mean rather different things. The idea was first promoted as a means of augmenting vertical HIV/AIDS programmes. Specialist HIV/AIDS/STI programmes were often divorced from other parts of government and had neither the resources nor the mandate to address the economic and social factors that increase vulnerability to HIV/AIDS. It was thought that harnessing other sectors would not only increase the resources available to respond to HIV/AIDS, but would also encourage new and more broad-ranging approaches.

For some HIV/AIDS policy-makers, however, multi-sectoralism is defined fairly narrowly. It effectively means inviting non-health government officials to join HIV/AIDS programme committees and/or giving different ministries responsibility for providing HIV/AIDS services to their employees. Multi-sectoralism can be made more effective when it encourages other organisations to adapt their core practices to support government HIV/AIDS prevention and care programmes. In Lesotho, for example, the Ministry of Justice through the Law Reform Commission has drafted the Sexual Offences Bill, which addresses issues including domestic violence and rape. A draft equality bill is also in place in an effort to uplift the legal status of women and to improve their property rights including inheritance issues. The police force has been conducting campaigns on crime and HIV/AIDS throughout the country. This broad-ranging approach to multi-sectoralism may be more time-consuming to achieve than simply improving employee-access to condoms and information about HIV/AIDS. When successful, however, it can make the

environment more conducive to making safer choices and promoting the well-being of people affected by HIV/AIDS.

Botswana's national policy stresses the importance of a multi-sectoral response in the prevention of HIV transmission and the care of PLWHA. All sectors, ministries, para-statal organisations, the private sector, and relevant NGOs and community-based organisations (CBOs) should develop their own prevention strategies. Communities should also be mobilised to become more actively involved in the development of HIV/AIDS prevention and care policies, particularly in the problem-definition and implementation-design stages. The policy sets out clearly the roles and responsibilities of various key agencies including the Office of the President, government ministries, local government agencies and private sector organisations with the Ministry of Health as 'lead ministry.'

Lesotho also advocates a multi-sectoral approach, though less precisely than Botswana. All ministries should develop their own prevention strategies and a 'multi-sectoral implementation framework' should exist, formed from representatives of 'all ministries at different levels, the districts, United Nations (UN) theme group, NGOs and bilateral donors, "all churches," and traditional leaders.' Multi-sectoral AIDS committees should also be established at the district level. A multi-sectoral Lesotho AIDS Programme Coordinating Authority (LAPCA) will act as a secretariat to the highest policy-formulating level, the National AIDS Committee. Though the approach is still in its early days, it has achieved some interesting results. The Ministry of Works, for example, has trained all its personnel on HIV/AIDS, and the training unit for construction work has reviewed training curricula to include HIV/AIDS issues. All contractors are now required to provide HIV/AIDS information to labourers and to provide condoms and other protective items.

Malawi's National Response to HIV/AIDS 2000-2004 was prepared after broad, multi-sectoral consultation and stresses that multi-sectoralism will be a key part of its overall strategy to address HIV/AIDS. The strategy document also lays out guidelines on the roles different ministries and groups should adopt in the fight against HIV/AIDS. Emphasis should be put on district and community-based responses, using local institutions such as Sectoral Planning Committees and Area and Village Development Committees.

Mozambique's National Strategic Plan 2000-2002 adopts an innovative approach to multi-sectoralism. It is both decentralised and multi-sectoral with co-ordination provided by the National AIDS Council, whose Executive Secretary reports to the Prime Minister. The plan defines clear strategic goals for each line ministry and allocates responsibility for particular vulnerable groups to particular ministries. Thus, the Ministry of Youth, Culture and Sport focuses on out-of-school youth, the Ministry of Education on in-school youth and the Ministry of Social Action on orphans, vulnerable women and high-risk groups of mobile labour, and so forth. Budget requirements are laid out by province and by line ministry.

South Africa's Strategic Plan 2000-2005 is firmly committed to a multi-sectoral approach and gives particularly detailed guidance about how this will be achieved and co-ordinated.[5] All members of cabinet, plus deputy ministers and members of the Department of Health meet monthly at the Inter-Ministerial Committee on AIDS to review the country's response to the epidemic. The South African National AIDS Council (SANAC) is a multi-sectoral committee chaired by the Deputy-President consisting of the representatives of 15 government agencies and 16 civil society sectors. These groups are named and have a mandatory right to representation on the committee. Other multi-sectoral bodies include an inter-departmental committee on AIDS which co-ordinates HIV/AIDS activities in government departments. HIV/AIDS is a standing item on various other government committees.

Swaziland's strategic plan also advocates a multi-sectoral approach, and clearly sets out the responsibilities of the Cabinet Committee and an HIV/AIDS Crisis Management and Technical Committee. It also sets out the objectives and strategies of 28 different sectors in their response to the epidemic. However, with only a small number of exceptions, these strategies are based around ministries providing more effective HIV/AIDS services to their staff: improving access to condoms, information campaigns and care for those on their staff, rather than adapting their core practices to support the government's HIV/AIDS campaigns. An exception is the Ministry of Agriculture and Co-

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[5] *HIV/AIDS and STD: Strategic Plan for South Africa*. Ministry of Health. South Africa. 2000, p. 8.

operatives, which undertakes to encourage communities including PLWHA to grow, prepare and eat nutritious diets.

Written in 1995, when the principle of multi-sectoralism in HIV/AIDS interventions was still evolving, Tanzania's policy is relatively brief on the subject. A National AIDS Control Programme in the Ministry of Health is responsible for the control and prevention of HIV/AIDS. It does recognise, however, that the issues involved are multi-sectoral in nature and undertakes to create multi-sectoral committees to co-ordinate the different sectors.

Zimbabwe's approach to multi-sectoralism is that HIV/AIDS can only be brought under control through a sustained and coherent, multi-sectoral approach to combat the epidemic. The government undertakes to facilitate the establishment of an 'appropriate' AIDS co-ordination and advocacy framework, including a multi-sectoral National AIDS Council with a clear mandate to ensure overall management of the national response to HIV/AIDS. It is less clear than other policies, however, on how the principle of multi-sectoralism will be implemented.

3. Human Rights

Most of the national policies and plans make clear statements that they support the human rights of PLWHA. All condemn the stigmatisation of PLWHA and state that people should not be discriminated against on the basis of their HIV status. However, the way these 'rights' are conceived and elaborated upon varies from country to country. Throughout the region, there is a tension between an acceptance of PLWHA's rights on the one hand, and a concern about the spread of infection through reckless or wilful behaviour on the other. There is also some cause for concern in that several of the policies refer to 'education campaigns' as being their main means of stopping discrimination. The term 'education' is sometimes used as a catch-all strategy for avoiding problems such as discrimination, but policy objectives are often better achieved if they are supported by clear legal or professional sanctions.

Botswana addresses the rights of people with HIV/AIDS, recognising that they exist and that there are both ethical and pragmatic public health reasons for reducing

stigmatisation and discrimination. It upholds the principles that PLWHA should be enabled to lead productive lives of good quality for as long as possible, and that discrimination should be reduced to ensure the effective co-operation of PLWHA. Botswana's policy undertakes to develop legislation to protect these rights where necessary. It does, however, warn that the rights of PLWHA should be balanced with the responsibility to protect others from infection. Those who deliberately attempt to infect others will be dealt with under the country's Public Health Act.

Lesotho's policy is clear that persons living with HIV/AIDS have the same rights as any individual, especially the right to non-discrimination. As with its policy towards multi-sectoral home-based care, Lesotho's approach recognises that general principles of human rights need to be supported with appropriate and accessible legal support for those who have been targets of discrimination. 'People who suffer discrimination due to HIV/AIDS will be supported *to seek legal recourse* through the appropriate channels. Government shall adopt specific policies and promulgate appropriate laws to protect human rights of all, particularly the infected and affected persons.'[6]

Malawi's 2000-2004 strategy document illustrates the tension that sometimes exists between the recognition of human rights on the one hand, and the desire to control HIV transmission through influencing behaviour on the other. In one respect, human rights are central to Malawi's response. The third of Malawi's ten guiding principles is that PLWHA have the right to protection against stigmatisation and discrimination. Other guiding principles are that laws should protect the legal and human rights of PLWHA and mitigate the suffering and economic deprivation of PLWHA, widows, widowers and orphans. Existing statutes protecting children and youth should be enforced at all levels. Other parts of the strategy, however, contain sections that have a strong moral tone. The first challenge in Malawi's 'Agenda for Action' is to address cultural values, beliefs and practices that predispose people to HIV infection.[7] Its key strategic actions are to identify and modify these values, including exploring the possibility of legislating against the 'values and beliefs' which put people at risk of HIV infection. What this legislation

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[6] *Policy Framework in HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 2.
[7] *Malawi's National Response to HIV/AIDS for 2000-2004: Combating HIV/AIDS with Renewed Hope and Vigour in the New Millennium.* Strategic Planning Unit. National AIDS Control Programme. Malawi. January 2000, p. 11.

might entail is not made explicit, but criminalising individual 'values and beliefs' may itself be problematic in terms of human rights.

The Mozambique Action Plan calls for the Ministry of Justice to integrate legal aspects of HIV/AIDS into its on-going Legal Reform. Specific areas mentioned include discrimination against PLWHA, and inheritance and property rights including those of orphans. The Ministry of Women and Co-ordination of Social Action is charged with assisting in the adoption of new legislation for inheritance rights, 'contemplating the problem of AIDS orphans.'[8]

Tanzania's policy is clear and explicit on human rights. Persons with HIV infection with or without AIDS shall be guaranteed all basic rights such as the right protection of privacy, to employment, to education and to housing. Zimbabwe frames the problem slightly differently arguing that the rights and dignity of all people should be respected, irrespective of their HIV status. However, because of the stigma still attached to HIV/AIDS the rights of PLWHA need special consideration. Equally, however, 'it must… be recognised that with rights come responsibility. The responsibility to protect oneself and others from HIV infection should be upheld.'[9]

Greater Involvement of PLWHA in Policy (GIPA)

Policies in Botswana, Lesotho, Malawi, South Africa and Tanzania all state that PLWHA should be actively involved in HIV/AIDS policy. This principle, which has become known as the Greater Involvement of People Living with HIV/AIDS (GIPA) Principle, has been strongly endorsed by UNAIDS as being an important part of developing effective, fair and practical HIV/AIDS policies. The countries frame the principle rather differently, however. 'Involvement' can be viewed in different ways and for different purposes. It can be seen in a purely instrumental way, involving PLWHA in education campaigns, for example, to underscore the 'safer sex' message. On a more profound level, however, the principle can be seen as involving PLWHA at all levels of decision-making. To do so makes policy and programming more effective and sends out a clear message that PLWHA are a valuable human resource, in spite of their HIV status. Having HIV positive

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[8] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, pp. 53, 58.
[9] *National Policy on HIV/AIDS for the Republic of Zimbabwe.* Harare. December 1999, p. 2.

people in high profile, decision-making roles can also help to break down discrimination and reduce the sense of isolation of those people affected by AIDS.

Botswana's policy does not include a GIPA principle, though it does say that communities in general will be mobilised to become actively involved in all stages of policy development, particularly in defining problems and designing interventions.[10] Mozambique states that PLWHA should be a core part of the national response, being actively involved in the fight against HIV/AIDS. PLWHA will be recruited to become AIDS activists and 'utilised' to reduce the stigma against AIDS. Lesotho's policy makes the more modest assertion that PLWHA should be empowered to participate actively and openly in information and education campaigns. Malawi does not make PLWHA involvement a strong part of its approach to HIV/AIDS, but mentions that NGOs, religious organisations, CBOs and youth organisations – and PLWHA – will form the core of implementing agencies.

Employment

SADC has prepared a code on HIV/AIDS and employment: A Human Rights Approach to AIDS Prevention at Work,[11] which upholds core human rights principles in respect of employment: non-discrimination and confidentiality. Botswana's national policy sets out the core principles surrounding HIV/AIDS and employment very carefully. Workers who are infected with HIV that are healthy will be treated the same as any other worker. Pre-employment testing should not be carried out and HIV status will not be grounds for dismissal. Workers who have acquired HIV-related illness and AIDS should be treated the same as any other worker and should be retained as long as they are medically fit to work. HIV-infected employees should have access to and receive appropriate benefits and should be protected against discrimination by colleagues, employers, unions and/or clients. Organisations should include aspects of this protection in workplace education campaigns.

Lesotho recognises the impact of HIV/AIDS on the workplace and the burden it is likely to place on employers and has developed a robust set of guidelines surrounding

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[10] *Botswana National Policy on HIV/AIDS.* Ministry of Health. Botswana. November 1993, p. 5.

HIV/AIDS and employment. It recommends that HIV/AIDS/STI prevention and care shall be implemented at the workplace and that employers *will be required* to provide HIV/AIDS/STI education and counselling to all their employees. Confidentiality must be maintained about all medical information surrounding HIV/AIDS. Employees are not required to divulge their HIV status, and employers may not seek such information about their workforce.[12] Mozambique's strategic plan charges the Ministry of Labour to move the HIV/AIDS and Employment Code through approval in the National Assembly.[13]

Tanzania's policy is commendably clear on the subject of discrimination in the workplace. Pre-employment testing is unnecessary and shall not be required. This applies to direct methods, such as HIV testing, and to questioning the applicant about HIV tests already taken. All medical information shall be kept confidential, employees are not obliged to inform their employers about their status. People who are infected must be protected from stigmatisation and prejudice. HIV infection shall not be cause for termination of employment and persons with HIV should be allowed to work so long as they are medically fit for available, appropriate work.[14]

Swaziland's employment strategy is less tightly focused on human rights. Its main objective is prevention and control of HIV/AIDS infection among the economically active. Over the next five years, Swaziland's employment policy is to promote awareness of HIV/AIDS, provide care and support for affected employees and to encourage employers to adopt non-discriminatory HIV/AIDS policies. It does, however, also undertake to ensure job security for infected and affected employees and ensure confidentiality and voluntary counselling and testing (VCT).

Zimbabwe's guidelines on testing for HIV/AIDS are dealt with under the Statutory Instrument 202 of 1998 Labour Relations (HIV and AIDS) Regulations, Sections 4, 5 and 6. Employers do not have the right to test people for HIV/AIDS and by itself, HIV infection is not grounds for dismissal.

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[11] *A Human Rights Approach to AIDS Prevention at Work: The Southern African Development Community's Code on HIV/AIDS and Employment.* UNAIDS. Geneva. 2000.
[12] *Policy Framework in HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 13.
[13] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, p. 57.

Somewhat obliquely, under a section on preserving 'marital integrity,' Zimbabwe refers to the problem of workplace practices that discourage families from living together. Marital integrity, it argues, should be a 'primary objective of society', and government should ensure 'as far as is possible… that where both spouses are in employment, their places of work are proximate so as to facilitate cohabitation and the establishment of a stable family home.'[15] This approach is echoed in Swaziland's strategic plan, which includes a reference to encouraging the private sector to provide 'family friendly' accommodation for its workers and undertakes to develop policies that will discourage separation of spouses. Migrant labour is widespread in the SADC region. Many large employers refuse to allow worker's families to live in traditionally single-sex workplace dormitories. Evidence suggests that this can lead to family breakdowns and an increase in casual sex and sex work. SADC offers a prime forum for addressing these issues on a regional basis, ensuring regional standards on conditions of employment and HIV/AIDS interventions in the workplace.

Travel

In accordance with international guidelines on travelling for HIV-positive persons, the national policies of Botswana, Lesotho, Tanzania and Zimbabwe state explicitly that there will be no restriction placed on travel by persons known or suspected to have HIV/AIDS. Foreigners will not be restricted entry. Tanzania's policy, however, retains the caveat 'except in exceptional circumstances.'

Wilful Transmission

The issue of how to deal with people deemed to have recklessly or wilfully transmitted HIV/AIDS is clearly controversial. As a general principle, the international AIDS community regards punishing people for transmitting AIDS as cumbersome, expensive and counter-productive to public health. Such criminal cases are very difficult to prove. To find defendants guilty, it would be necessary to establish that they knew they were HIV-infected and that they had a criminal intention of transmitting it to their partners. It

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[14] *National Policy on HIV/AIDS/STD*. National AIDS Control Programme. Tanzania. September 1995, p. 20.

[15] *National Policy on HIV/AIDS for the Republic of Zimbabwe*. Harare. December 1999, p.7.

would also mean establishing that the alleged 'victims' were infected by the defendants, and that they had not been told of the other persons' HIV status. Even if all these conditions can be met, it may be difficult to establish criminal intent in someone who may have been disturbed and traumatised by the knowledge of his or her HIV status.

As well as being impractical, however, this type of criminal legislation runs counter to the general, non-discriminatory spirit of public health responses to HIV/AIDS. Public health campaigns have tried to emphasise the point that HIV infection can happen to anyone, and that everyone should take responsibility for their own exposure to risk. Criminal trials of PLWHA imply that some 'guilty' people are endangering innocent 'victims'. As such, the trials are likely to foster the stigmatisation of PLWHA. Such court cases have often been accompanied by lurid press articles, controversy and, in extreme cases, scenes of racist, homophobic or religious-based public disturbance. There are also fears that criminalising HIV transmission is likely to act as a disincentive to people to come forward for testing and treatment. If someone has never had an HIV test, he or she cannot be convicted of 'knowingly' transmitting infection.

Despite this, policy-makers often prefer to retain some form of sanction against extreme, irresponsible or reckless behaviour. The UNAIDS Handbook for Legislators on HIV/AIDS recommends that detention or criminalisation of PLWHA should only be based upon extreme individual behaviour under generic laws rather than based on their HIV status *per se*. Many countries throughout the world have mechanisms for dealing with wilful transmission in their public health legislation. Botswana, for example, has provisions for wilful transmission under its Public Health Act (Section 11). Care, however, should be taken not to extend existing public health legislation carelessly or inappropriately. Public health legislation was often developed to control infectious diseases rather than merely transmittable ones. UNAIDS reports that simply extending this legislation to cover HIV/AIDS can lead to unworkable situations in which PLWHA may, for example, be technically prohibited from using public transport.

Another approach is to adopt specific HIV-related legislation. Lesotho's policy framework recommends that legislation be put in place to protect people from deliberate infection. Swaziland's strategic plan goes still further and undertakes to make transmission of HIV/AIDS a criminal offence, whether transmission is wilful or through

negligence. Malawi's strategy undertakes to initiate debate on legal issues such as the legalisation of sex work and criminalisation of the wilful spread of HIV/AIDS. Tanzania's policy approach places great emphasis on the responsibility of individuals not to transmit HIV and it states clearly that HIV-infected individuals aware of their being infected who indulge in unprotected sex 'shall be punished.'[16] Later it states that criminalisation of wilful spread of HIV/AIDS/STIs will be encouraged. Zimbabwe's policy on wilful transmission is somewhat confusing. Having outlined the public health arguments for *not* criminalising wilful transmission, the policy states that it should be considered a crime in the same sense as inflicting other life-threatening injuries to another. It then recommends developing appropriate legislation.

Confidentiality

Botswana's policy clearly upholds the principle of confidentiality, stating that information about the HIV status of individuals, including patients and employees, should not be divulged without consent. It does, however, also uphold the principle of 'shared confidentiality', that is informing those who need to know in order to provide appropriate health and social care. Family members 'should be involved from the outset in the management of persons with HIV/AIDS,' but there is no policy of informing sexual partners of a patient's HIV status without their consent. The policy states "Notification of sexual partners should be done with consent of index persons." Similarly, Tanzania's policy states that all testing will be confidential, explaining that breaches of confidentiality destroy the trust that is essential between the testing programme staff and the individuals and groups involved. Such a breach of trust may have a serious, even irreversible, effect on the programme.

Lesotho's policy also upholds the principle of confidentiality, but for 'shared confidentiality' between appropriate health and welfare professionals and/or family members who are providing care for the infected persons and who stand at some risk of infection. The policy does, however, allow for breaking confidentiality when, after repeated counselling, an HIV-positive person continues to refuse to notify or consent to the notification of his/her partners. Mozambique's strategic plan charges the Ministry of

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[16] *National Policy on HIV/AIDS/STD.* National AIDS Control Programme. Tanzania. September 1995, p. 8.

Justice to develop codes to 'respect norms for … confidentiality of individuals' serological state.'[17]

Zimbabwe's policy affirms that confidentiality over health matters is a basic human right and a fundamental principle of ethics of medical practice. Having stated that, however, it follows with a detailed discussion of the pragmatic public health issues surrounding the issue of confidentiality. Even without consent, information can be disclosed to a third party in the case of specified notifiable diseases under the Public Health Act where appropriate public health interventions can be applied. Sexual diseases are a notifiable disease in Zimbabwe (see Section 4 on Testing, below). It also argues that excessive emphasis on confidentiality may lead to increased stigma and perpetuate denial of the problem. During the policy development process, it explains, calls were persistently made to develop and enforce a practical legal framework for disclosures of one's HIV status to be made by health professionals to those who have critical reasons to know, even if consent is denied.[18] Such a possibility is to be explored.

Insurance

If people are not to be discriminated against on the grounds of their HIV status, it follows that they should be able to obtain insurance. In practice, however, the question of insurance and HIV remains highly contentious. The insurance industry is perhaps understandably anxious to control potentially vast liabilities, and governments around the world have often proved unwilling and/or unable to limit the industry's commercial autonomy. Tanzania's policy states clearly but briefly that HIV-infected persons have the right to insurance. Lesotho addresses the issue in more detail, stating that persons infected with HIV should not be denied insurance. HIV testing for the purpose of obtaining an insurance policy may be required, but pre- and post-test counselling must be made available. HIV/AIDS should be treated like analogous medical conditions, with exemptions reliant on reasonable actuarial data. When a person dies of an HIV/AIDS-related illness, his/her surviving family should not be denied benefits. Zimbabwe deals with insurance under the guidelines in the Labour Relations (HIV/AIDS) Regulations, 1998, Section 7, which were not available for review. In its national policy, however, it

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[17] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, p. 58.
[18] *National Policy on HIV/AIDS for the Republic of Zimbabwe.* Harare. December 1999. p. 6.

states that the government should assess the impact of insurers' demands for HIV tests before an insurance policy is adjudicated. The insurance industry should develop and apply policies that take into account the needs of persons with HIV/AIDS. Botswana addresses the issue of testing by insurance companies by requiring them to ensure that counselling accompanies all testing.

Prisons

Lesotho's policy states that prisoners and people in institutional care shall be provided with appropriate information about HIV, VCT and appropriate care. Prison authorities should be encouraged to take all necessary measures to protect inmates from rape, sexual violence and coercion. Inmates should not be discriminated against and may be considered for compassionate early release to allow them to spend their last days at home. Mozambique's strategic plan considers prisoners a primary 'vulnerable group.' It mentions the need for condoms in prisons and charges the Ministry of Justice with overturning the prohibition of condom promotion in prisons.[19] Zimbabwe's national policy acknowledges problems of overcrowding in prisons. It recommends improved surveillance and supervision to prevent both consensual and forced sexual activity in crowded prisons. Prisoners have the right to information about HIV/AIDS. Compulsory testing and segregation of HIV-positive prisoners infringes on their basic rights. HIV testing should be voluntary and accompanied by pre- and post-test counselling. Principles of confidentiality and informed consent apply.

Homosexuality

Lesotho is the only country that has a specific policy on homosexuality, saying only that homosexuals should be encouraged to come forward for education on HIV/AIDS and on the proper use of condoms.

4. Testing

UNAIDS recommends that testing for diagnosis should be voluntary. Given the long incubation period of the HIV virus and the on-going opportunities of infection from it, mandatory testing can be regarded as an expensive, inefficient and abusive form of

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[19] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, pp. 14, 58.

attempting to control HIV. Voluntary testing allows people to wait until they are (relatively) psychologically prepared for the results. Public health requirements, however, require certain exceptions to this general principle. Clearly, donated blood must be screened (see Section 9 on Safe Blood, below). More broad-ranging testing may also prove necessary to allow public health officials to monitor the spread of the disease. These tests, however, should be anonymous and unlinked; that is, all names and identifiers should be removed from the blood specimen.

Botswana's testing protocols are set up in the Ministry of Health's policy on HIV/AIDS,[20] which upholds the principle that testing for diagnosis should be voluntary. Surveillance testing is anonymous and unlinked. Routine testing should not be carried out, and testing should not be done without the knowledge of the subject. Counselling should be offered and confidentiality maintained. It states that pre-employment testing is unnecessary and should not be conducted.

Lesotho's policy gives clear guidance about testing. Testing for diagnosis should be voluntary, linked and confidential. Pre- and post-test counselling and informed consent are required. Testing for sentinel surveillance is unlinked and anonymous. Pre-employment testing is unnecessary and should not be carried out. HIV testing should not be carried out as part of a periodic medical examination. Testing for rapists and suspected rapists will be mandatory, but counselling shall be provided. Testing for victims will be free, voluntary and confidential. Pre-conception testing and counselling should be encouraged.

Blood safety is an integral part of Swaziland's risk reduction strategy. Its strategic plan does not, however, go into details about how that is to be achieved, other than adopting uncontentious strategies like ensuring '100% safe blood supply and blood products,' and updating national blood transfusion policies.

Tanzania's policy gives very detailed guidelines on testing.[21] Testing should be either unlinked (anonymous) or voluntary and linked so that test results can be communicated

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[20] Ministry of Health, Botswana. NAPC Series Number 5.

[21] *National Policy on HIV/AIDS/STD*. National AIDS Control Programme. Tanzania. September 1995, p. 6.

to the patient or, in the case of minors, to their parents or guardians. Somewhat confusingly, however, it states that 'all endeavours should be made' to make blood transfusion tests *unlinked and* that the obtained results should be communicated to the blood donors (italics added for emphasis).[22] In planning anonymous but linked testing such as cohort studies, test subjects should know in advance that they will be tested and they should be told their test results. All research protocols and proposals involving HIV testing of subjects must conform to this policy and be approved by the Ministry of Health or the responsible hospital ethical committees. Research requiring international collaboration and HIV testing of human subjects must be approved by the Chief Medical Officer following the advice of the research and ethical sub-committee of the Health Sector Technical AIDS Committee.

Zimbabwe's policy on HIV/AIDS addresses the issue of client testing in great depth. Surveillance data for HIV/AIDS is obtained through anonymous and unlinked screening. All testing should be subject to client consent. The client should be fully counselled prior to testing and have discussed the social and medical implications of the test. Until the legal age of consent, a child is considered a minor and consent is obtained from parents or a legal guardian. Where 'cognitive impairment' has occurred, and there is no valid reason for a test, no test should be carried out. If medical grounds for testing exist, consent should be obtained from the appropriate next of kin or the head of the medical institution. In a separate section, it states that persons charged with any sexual offence that could involve the risk of HIV transmission should be required to take a test. The assaulted person should be offered voluntary testing and, where appropriate, treatment by the state.

More problematically in terms of human rights, however, sexually transmitted diseases are currently a notifiable disease under the Public Health Act Chapter 15:09. This means that the personal details of people found to be HIV-positive are systematically recorded. The policy undertakes to look into the question of notification and confidentiality in the future.

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[22] *National Policy on HIV/AIDS/STD*. National AIDS Control Programme. Tanzania. September 1995, p. 7.

5. Voluntary Counselling and Testing

Current international guidelines on counselling and testing suggest that testing should be done on a voluntary basis and that counselling should be made available before tests are done and when results are made available. Pre- and post-test counselling provides a valuable opportunity for information and education on sexual health and encourages more positive, appropriate and responsible behaviour from people who may otherwise react to their test result with extreme anger, distress or denial. Effective counselling provides psychological and social support to enable those infected and affected by HIV to deal with a wide range of emotional, social and medical problems. It also serves to enable the persons concerned to prevent HIV infection by enabling them to assess and understand risky lifestyles and define their potential for behaviour change.[23]

Lesotho's national policy espouses the principle of pre- and post-test counselling and also states that counselling services should be extended to include spouses and family members. Malawi accepts the principle of voluntary counselling and testing and links the uptake of voluntary testing with discrimination. Increased information, education and communication (IEC) and more vigorous application of legal and human rights codes would encourage people to come forward for testing. It also lays out relatively detailed guidelines on how VCT in Malawi could be improved and expanded. VCT is a priority of the Mozambique strategic plan and is listed as an 'essential activity.'[24] The Ministry of Health has a target of conducting 50,400 voluntary tests and counselling sessions by the year 2002. Similar activities are targeted within the ministries of National Defence and Justice.

Tanzania upholds the principle of voluntary testing and states that pre- and post-test counselling should be provided where testing is done. Unlike other SADC countries, however, its policy is to inform blood donors and surveillance test subjects if they are found to be HIV-positive. Results should be communicated by qualified medical practitioners. Zimbabwe's Policy on AIDS considers counselling to be a vital component of its prevention, control and care. Counselling should be accessible to all people affected. It undertakes to make appropriate training in counselling available and to

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[23] *National Policy on HIV/AIDS for the Republic of Zimbabwe.* Harare. December 1999, p. 15.

establish minimum standards for such training. Testing for diagnosis should be voluntary and accompanied by counselling.

6. Behaviour Change/IEC

Pending the discovery of a vaccine or cure, Behaviour Change Communication (BCC) and/or IEC remain the most important ways of controlling HIV transmission. The ultimate goal of BCC/IEC messages should be the promotion of safer sexual behaviour. In the past, interventions have tended to focus on simply giving people information about the disease, the assumption being that having the information would automatically translate into changed behaviour. Experience in IEC has demonstrated that this link can not be assumed. For any number of reasons, people who understand the risks involved in particular actions may continue to do them. Some people choose to ignore the information they have received, thinking it will not affect them. Vulnerable groups, particularly poor women, may find it difficult to negotiate safer behaviour. Some are economically dependent on a spouse or on sex work or sexual favours. Thus, they are effectively unable to 'choose' not to expose themselves to risk. For this reason, BCC has begun to take a more broad-ranging approach to changing behaviour. Interventions may include peer-advocacy, assertiveness training, education and even income-generation activities, all of which are aimed at empowering people to reduce their risk of HIV infection.

Botswana cites IEC as a key component of its policy. IEC should use different media and should be aimed at different target groups. Botswana has a national IEC strategy that recognizes behaviour change as a critical component. Lesotho stresses the importance of IEC, discussing the promotion of 'responsible sexual behaviour,' including 'abstinence and delay of initiated sexual adolescents and the promotion of condoms.'[25] It also warns that messages should 'take into account the religious, social and cultural circumstances of the audience,' and that traditional values that promote positive and responsible sexual behaviour should be emphasised. Malawi's strategy document also stresses the importance of IEC, and outlines the necessity of developing a 'standardised, comprehensive and effective strategy to reduce the spread of HIV and

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[24] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, pp. 39-40.
[25] *Policy Framework on HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 9.

cope with its impact.'[26]   IEC and BCC are also core elements of the Mozambique Strategic Plan and are cited in virtually every chapter of the document.   Community mobilisation and theatre and drama account for 11% of the requested provincial budgets for prevention.[27]

South Africa takes a relatively broad approach to promoting 'safe and healthy sexual behaviour.' Recognising that people's health-seeking behaviour is affected by the context within which they must make choices, South Africa seeks to make the environment more conducive to making safer choices, for example, by promoting health services that are 'youth-friendly.' Apart from producing and disseminating IEC material to different stakeholders, the country will implement 'life skills' education in primary and secondary schools and broaden responsibility for the prevention of HIV to all sectors of government and civil society (see Section 2 on Multi-sectoral Approach, above).

Swaziland's strategic plan makes IEC and the promotion of behaviour change the core of its HIV/AIDS strategy. The 2000-2005 strategic plan sets the goals of delaying sexual debut and reducing new HIV infections by 50% by 2005.   Its strategies for achieving these goals include developing a national HIV/AIDS system and integrating HIV/AIDS information into service delivery points in all sectors, including ministries, schools and places of work. It also stresses the importance of peer education at all sectors at all levels. Unusually, it makes the promotion of Christian values an explicit part of its BCC strategy.

Tanzania makes IEC a core part of its strategy for controlling HIV transmission. It sets out clear government goals, promoting awareness about HIV/AIDS/STIs to a level where all are familiar about the facts of HIV transmission; individuals are able to assess their own risk and make safer decisions; and where myths and prejudices are reduced to insignificant levels. It also states that appropriate education on reproductive health should be integrated into school and training institutions' curricula.   Targeted interventions should focus on groups involved in 'high-risk behaviours.'

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[26] *Malawi's National Response to HIV/AIDS for 2000-2004: Combating HIV/AIDS with Renewed Hope and Vigour in the New Millennium.* Strategic Planning Unit. National AIDS Control Programme. Malawi. January 2000, p. 19.
[27] *Action Plan to Fight HIV/AIDS in Mozambique: Resource Requirements for 2001-2003.* Maputo. November 2000.

Zimbabwe's policy has an interesting approach to IEC, stating that its development should be based on participatory methods involving the intended target audience/population. It has been well established that IEC messages are more successful if they are written in an appropriate language and address what are usually highly contextual fears, norms and taboos. Families and extended family members should be encouraged to discuss sexuality and STIs. By making participation an explicit part of its strategy, it increases the chance that participation in IEC will become a routine part of campaign development.

7. Condom Promotion

Condoms are widely recognised as being an effective way of preventing infection with HIV and other STIs. With the high rates of HIV prevalence in the region, condoms remain an absolutely key element of an effective HIV prevention strategy. Uganda, which is one of the first countries to have successfully reduced the incidence of HIV, has strongly supported the promotion and widespread distribution of condoms. Condoms are, however, controversial. Condoms are considered offensive to some religious groups. Many people, including senior policy-makers, see the promotion of condoms as effectively condoning promiscuity and extra-marital sex. Promoting condoms among youth and in schools is particularly contentious, as to some it may appear to provide adult sanction of 'precocious' sexuality. Botswana's national policy addresses condoms as part of its strategy for dealing with STIs: the promotion and efficient distribution of condoms to appropriate population sub-groups including youth, women, men, workers, and so forth. Lesotho's policy recognises the effectiveness of condoms in preventing transmission of HIV, and undertaking to actively promote both female and male condoms (taking into account the socio-economic and cultural environment). It also undertakes to make condoms widely available at affordable prices through social marketing schemes. Appropriate mechanisms for ensuring the quality, proper use and disposal of condoms will be instituted.

Malawi's strategy document is unambiguous about the importance of condoms to the general population as well as to specific target groups. It does not, however, say how it will improve access other than that it will advocate for increased use of condoms and for their wider provision. It will also strengthen co-ordination in the procurement, quality

control and distribution of condoms. South Africa and Tanzania expanded promotion of and access to condoms, including for youth. Tanzania's policy specifies that education on condoms should be available at school, but draws the line at distributing condoms in schools, for fear that it implies encouragement of sexual practices in schools.[28] Mozambique has supported donor-funded condom social marketing since 1995 and condom promotion is cited throughout the strategic plan.

Zimbabwe has a very clear policy on condoms and barrier methods. Both male and female condoms greatly reduce the risk of HIV/STIs. They should be made available, accessible and affordable to all sexually active people through a variety of distribution channels.   Condom quality should be ensured by adherence to requirements for registration under the Medicines and Allied Substances Control (condoms) Regulations (1991). Condom projects should include comprehensive information and instructions in the relevant language.

8. Prevention of STIs

STIs and HIV/AIDS are closely linked. Having an STI is an indicator of risky behaviour. More important, many STIs, particularly those associated with genital ulcers, increase vulnerability to infection with HIV. Ideally, therefore, responses to HIV and STIs should be interlinked. The fact that many national AIDS programmes also have jurisdiction over STI control is recognition of the inter-dependency. Lesotho goes one step further than this, outlining the way STIs should be prevented and controlled.   Syndromic management will be the main strategy for dealing with the problem, and STI case management will be integrated into primary health care facilities, including those of the private sector. Effective drugs for the treatment of STIs should be available at these facilities. Botswana's policy outlines key components of a strategy to control STIs.

STI control is also a key part of South Africa's approach to controlling HIV.   South Africa's strategic plan espouses effective syndromic management of STIs in the public and private sector, and will also advocate collaboration with traditional healers to improve health-seeking behaviour for STI treatment. It sets out a series of strategies for

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[28] *National Policy on HIV/AIDS/STD.* National AIDS Control Programme. Tanzania. September 1995, p. 15.

achieving this, including investigating granting licenses to nurses for STI treatment, training, and considering referral systems between traditional and Western medicine.

Zimbabwe also has various suggestions for improving STI treatment, including improving contact tracing for STIs.[29] In a separate section, however, it suggests that contact tracing should be handled extremely sensitively, as it risks destroying the patient's confidence with the health advisor. Other methods of controlling HIV/AIDS include addressing the barriers faced by women and young people in seeking treatment for STIs, and upgrading STI management skills for all health personnel including community workers. Mozambique integrated STI management into the AIDS Control Programme in 1995, and the National Strategic Plan makes repeated references to STI control as an HIV prevention strategy.

9. Safe Blood

Blood transfusion is a potentially high-risk means of infection with HIV. The World Health Organisation (WHO) has been supporting safe blood schemes since the mid-eighties, and most countries have protocols surrounding the issue of blood transfusion and a means of testing blood. Botswana's national policy deals with safe blood issue succinctly: it will be achieved through the establishment of a sufficient pool of safe blood donors, a 'reliable blood transfusion service' and 'appropriate use of blood.' Similarly, Lesotho's policy framework briefly states that it will ensure that HIV is not transmitted through blood transmission and that blood donors will have their blood screened for HIV and Hepatitis B through internationally accepted methods.

Protecting the blood supply is a high priority in Mozambique. Although not mentioned in the strategic plan, the Ministry of Health's first priority for HIV kits is to test blood donations (followed in order by sentinel surveillance and confirmatory testing of suspected infections).[30] Blood is not considered to be a major channel of HIV transmission in Mozambique. South Africa's policy is to maintain a safe blood transfusion service, which will be achieved by monitoring implementation of current guidelines on HIV and blood transfusion and developing national guidelines.

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[29] Identifying and contacting all people who could have been infected by a person with a communicable disease.

[30] K. Foreit, personal communication.

Zimbabwe addresses the issue of blood donation comprehensively and imaginatively. Recognising the high risk of infection from blood and blood products, its national policy emphasises the continuing necessity to screen all blood for HIV before transfusion using procedures that meet national and international standards. Patients awaiting non-emergency surgery should be encouraged to 'bank' their own blood; and blood donation should be kept as a voluntary and non-remunerated service. Interestingly, the document also contains practical policies on how to minimise the necessity of transfusing blood and blood products. It will promote preventive health care to reduce the risk of anaemia, inform medical practitioners on how to avoid unnecessary transfusions and provide strict criteria for undertaking them. It will also adhere to the Essential Drugs List for Zimbabwe for use of blood and blood products.

10. Mother to Child Transmission (MTCT)

HIV can be transmitted from mother to child during pregnancy, during delivery and through breast milk. The risk of HIV transmission from mother to child is significant. None of the policies in SADC are particularly clear on how to address the issue, other than to say that it is important. Lesotho's policy states that HIV-positive mothers should be informed about the risk of pregnancy to themselves and to their children. The government 'shall endeavour to follow up scientific developments that are meant to protect babies from acquiring HIV from their mothers during pregnancy, at birth and during breast-feeding.'[31] Tanzania's policy undertakes to educate HIV infected women of child-bearing age and/or their partners about the risk of MTCT and offered the choice of contraception. South Africa has established pilot projects in two sites in each province and plans to expand this program nationwide in the next two years. Swaziland's strategy establishes the prevention of MTCT as a core goal, and sets out general strategies for achieving this, such as researching factors that influence MTCT, facilitating access to available treatment and developing a policy on MTCT and infant feeding. Similarly, Zimbabwe sets out the guiding principle that women and couples considering pregnancy should have access to accurate information about HIV infection and pregnancy, and to voluntary counselling and testing. It then sets out seven strategies for achieving this goal, including encouraging women considering pregnancy to seek

voluntary testing and counselling, increasing availability of counselling and testing and increasing access to information on MTCT. The Seychelles has provided PMTCT services since March 2000. Botswana adopted PMTCT as a key strategy in 1999 and expanded the program to all provinces in 2001.

11. Breast-feeding

The question of breast-feeding for HIV-positive women is contentious. For years, international organisations have tried to encourage mothers to breast-feed rather than bottle-feed. Breast feeding is 'universally affordably, uniquely nutritious, offers protection from most serious infant infections, ensures bonding between mother and baby and acts as a contraceptive.'[32] In general, bottle-feeding carries with it greater risk of illness, including potentially fatal diarrhoea, and malnutrition. Bottle-feeding, particularly in regions with widespread poverty – where clean water and sterilising equipment is rarely available – has been strongly discouraged by health professionals.

Problematically, however, babies who are breast-fed by their HIV-infected mothers are at risk of acquiring HIV. Research has not yet presented a clear solution to the dilemma. Some research indicates that exclusive breastfeeding for the first three months by mothers with HIV/AIDS does not increase the risk of transmission. Others suggest that formula milk is safer, but only if fed uninterruptedly. Mixing formula with solid foods or breast milk may increase the chance of infection. Breast-feeding also raises social issues. Some HIV-positive mothers are reluctant to bottle-feed for fear of stigmatisation. In places where the majority of mothers breast-feed, deciding to bottle-feed is effectively seen as evidence of infection with HIV.

There are various approaches to this dilemma in the SADC region. Lesotho's policy framework states that ultimately, only mothers themselves are in the position to decide whether or not breast-feeding is appropriate. They should, however, be counselled to make fully informed decisions. Mothers who opt for formula feeding will be provided with 'necessary support.' Tanzania's policy is more unequivocal, stating firmly that 'the risk of HIV transmission through breast-feeding is very much lower than the risk of death from

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[31] *Policy Framework in HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 16.
[32] *National Policy on HIV/AIDS for the Republic of Zimbabwe.* Harare. December 1999, p. 11.

diarrhoea and malnutrition for non-breast fed infants. HIV infected mothers will be encouraged to breast feed if they are physically fit.'[33] Zimbabwe's guiding principle on breast-feeding is that mothers should have viable options to ensure appropriate infant and child feeding. It then sets out strategies for achieving its goal, such as providing information and counselling; encouraging *all* breast-feeding women to use barrier protection methods to prevent early conception or HIV infection or re-infection; and supporting women who choose not to breast-feed with safe, affordable alternatives. Botswana's Draft Policy on Infant and Young Children Feeding promotes exclusive breastfeeding up to six months, followed by complementary feeding up to two years and beyond. The policy emphasizes the right of people to be fully informed on infant feeding choices and to be supported in the method that they choose.

12. Care for People Living with HIV/AIDS

The care of people living with, or affected by, AIDS represents an enormous challenge in Southern Africa. The public and private sector, NGOs and CSOs need to contribute to even begin fulfilling the region's care needs. In practice, much of the day-to-day responsibility for the care of PLWHA falls upon households and communities. Hospitals and medical centres are unable to cope with the increase in critical illnesses and patient numbers from HIV/AIDS. NGOs, governments and donors have sought to support these households with clinical outreach services (home-based care programmes). However, it is increasingly clear that the care needs of people with HIV/AIDS are not solely clinical, but also include psychological support and protection from discrimination and stigmatisation.

The government of Lesotho recognises the special needs of people with HIV and their families and undertakes to 'mobilise' government institutions, NGOs, religious organisations, the private sector and the community to provide care and psychosocial support. The government should ensure that adequate quantities of drugs are available for treating opportunistic infections. More important, it states that the government and its collaborative partners should promote a multi-sectoral response that would include assistance such as legal advice and welfare support (as much as prevailing economic conditions allow and provided that assistance is available to others with similar needs).

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[33] *National Policy on HIV/AIDS/STD.* National AIDS Control Programme. Tanzania. September

The government will also support the establishment of self-support and support groups for PLWHA.

Botswana works with the Network of People Living With AIDS to carry out needs assessments for PLWHA. Food baskets are provided to patients through the Ministry of Local Government.

Without going into operational detail, Swaziland's strategic plan recognises the importance of local communities and undertakes to improve care for PLWHA through the development of community-based care and increasing support via NGOs and CBOs. It does, however, include a section on 'positive living' and nutrition. A healthy diet and lifestyle can improve the well-being of people with HIV/AIDS and ultimately prolong life. Information and education campaigns on diet and lifestyle are included as part of Swaziland's policy on care for PLWHA.

Malawi recognises that HIV/AIDS care and support are inadequately co-ordinated and that services to PLWHA, their families and communities are poor. Strategic actions to address these deficiencies to institute mechanisms for referral between hospitals and community groups; to develop guidelines for allocating resources for HIV/AIDS care; to establish flexible welfare and credit schemes for PLWHA, orphans, widows and widowers; and to build capacity for care providers and PLWHA support groups. The Mozambique strategic plan cites care for PLWHA as a major national, regional and community priority. South Africa's policy is to improve home-based care by promoting the establishment of cross-sectoral task teams and to reduce stigma associated with HIV/AIDS by developing IEC materials targeted to communities. The Tanzanian policy is to provide hospital-based care and treatment of opportunistic infections. No health care institution shall have the right to refuse to provide treatment to patients on the grounds of HIV infection. Counselling should be a basic component in the care of HIV/AIDS patients. Home-based care should be encouraged and supported, with education provided to family members. Community-based support services should be encouraged.

1995, p. 18.

Zimbabwe sets out the general principle that comprehensive, cost-effective and affordable care should be made accessible to PLWHA. Care encompasses addressing physical, social and psychological needs. 'Care' is on a continuum, from professionals in hospital to family members at home. The policy also states that people with HIV/AIDS have the right to choose the type of care they want and should have access to accurate information about 'orthodox' and traditional medicine. Public awareness about the strengths and limits of different approaches should be made available. The policy then lays out guidelines designed to address traditional healing in national policy, including operationalising legislation that requires traditional healers to have to formally register, monitoring them, encouraging collaboration between orthodox and traditional practitioners, and instituting measures to control the claims of HIV/AIDS cures. Zimbabwe also sets out guidelines for community-based care, on the basis of its importance in terms of the continuum of care for PLWHA. It makes the useful point that community-based care should also cover people with other chronic and terminal illnesses. HIV/AIDS care programmes have sometimes been criticised for failing to address other health problems.

Care for Carers

Several of the policies deal with issues surrounding the care of care workers. Lesotho's policy states that post-exposure prophylaxis, follow up and counselling will be made available to health workers who are accidentally exposed to HIV-infected material during the course of their professional duties. The same measures should be taken for rape victims and home care providers. Similarly, South Africa aims to ensure supply of anti-retrovirals for public health workers who have been exposed to the risk of contamination, and to ensure appropriate policies in private sector health facilities. It will also access services for men and women following sexual assault. Mozambique's Ministry of Health has developed protocols for health workers exposed accidentally to HIV-infected materials, including limited anti-retrovirals.

Zimbabwe's policy also addresses the issue of the 'burn-out' of care providers involved in the often traumatic and exhausting business of caring for people with AIDS. Ignoring this problem, they argue, leads to diminished care and undermines the coping capacity of care givers. Its strategies for addressing this problem are to encourage health

professionals and non-professional care givers to provide support to each other in the form of back up, co-counselling and exchange. It also suggests establishing periods of respite for care workers, through community involvement and specially formed respite centres to offer short hospital (re)admissions for the client.

13. Gender

Women

Botswana's policy undertakes to promote gender equality in all spheres of national and community life, to enhance women's social and economic status, and to empower them for more effective participation in decision-making about sex. It identifies women's lack of empowerment as a factor making women more vulnerable to HIV/AIDS. Lesotho encourages 'women, youth, and all vulnerable and disadvantaged groups to protect themselves against HIV/AIDS/STIs.' Targeted training for women will aim at increasing self-esteem, assertiveness and capacity for decision-making in order to improve their negotiating position in sexual relationships. The government also undertakes to review religious, legal and cultural traditions that impact negatively on women. It acknowledges the high prevalence of violence and sexual violence against women by their spouses and that the government should promulgate laws and adopt specific policies to protect married couples regarding HIV/AIDS/STIs. Malawi also makes gender a key part of its approach, particularly in terms of the close links among gender, poverty and vulnerability to infection with HIV.   Issues surrounding gender equity and equality should be incorporated in all government programmes, and mechanisms for enforcing gender and human rights legislation should be strengthened. Mozambique's Strategic Plan cites women's status as a primary 'socio-community determinant' of the HIV/AIDS epidemic, including limited opportunity to negotiate the terms of sexual relationships, economic dependence and poor access to education.[34]

South Africa's strategic plan recognises that addressing women's vulnerability in society is key to ensuring that they are able to take effective measures to protect themselves against infection.   Similarly, the Tanzania policy states that improving women's economic status through such measures as credits, skills, training and employment

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[34] *National Strategic Plan to Combat STD/HIV/AIDS.* Maputo. February 2000, p. 12.

should be enhanced. Equal opportunities should be enhanced and women should be targeted for IEC campaigns.

Sensitivity to gender and commitment to promoting gender equalities is one of Zimbabwe's core strategies. Its policy recommends that men and women should be accorded equal status with equal opportunity for education and advancement. Their constitutional rights should be enforced in every sphere. Information about legal procedures, saving and investment rights should be included in school education, in appropriate languages and formats for the general public. It also has a specific section on gender-based violence, recommending the establishment of nationwide mechanisms for reporting sexual abuse, strengthening women's organisations and improving and expanding services such as income generation and support for women who are victims of domestic violence.

Men

Several countries make reference to the special role of men in the control of HIV/AIDS. Some countries have explicit guidelines for involving men in prevention activities. Botswana's stated policy, for example, is to target men for education activities to use their 'authority and power' to protect themselves, their partners and their families. It states that promoting male responsibility is critical to protecting both men and women against HIV infection. Lesotho makes men a priority in their education campaigns.

14. Youth

Young people are at a greater risk of infection with HIV/AIDS and other STIs than many other groups. Frequently, they lack access to adequate health information and education inside and outside school. Socially and economically vulnerable, they may find it difficult to negotiate sexual behaviour. Increasingly, for example, older men target school-aged girls for sexual favours, believing them to be more likely to be free from HIV infection. However, young people also provide a window of opportunity for policy-makers. In Malawi, for example, 98% of people under the age of 15 are HIV negative. Between ages 15-49, only 70% are. If interventions target young people effectively, policy-makers may begin to bring the epidemic under control.

Lesotho's policy states that HIV/AIDS/STI education should be integrated with the curricula of schools at all levels. Career and guidance counsellors will be designated and trained to offer counselling to youth. Healthy HIV-positive students will be treated the same as any student with regard to further training and education. It also states that 'efforts will be made' to improve the access of youth to confidential sexual and reproductive health services, including HIV/AIDS information, counselling, testing, life skills and prevention measures such as condoms and social support. Lesotho's policy framework specifically mentions parents, arguing that they have a role to play in the prevention of AIDS and should be 'oriented' towards greater openness about sexual and reproductive health issues.

Botswana addresses youth issues through its youth policy under the Department of Youth and Culture in the Ministry of Home Affairs.

There are some radical differences in approach to youth and HIV/AIDS/STIs within the region. South Africa makes youth a specific focus in the fight against HIV/AIDS. It suggests a broad-ranging approach that includes increasing access to 'youth-friendly' reproductive health services, including STI management, VCT and rapid HIV testing facilities. The implicit argument is that friendly staff will encourage young people to come forward for advice and treatment. Zimbabwe, however, adopts a very different approach to these 'youth-friendly' services. Having observed an increase in young people coming forward for advice and/or care for STIs and contraceptives, health care workers are advised to put increasing emphasis on abstinence, the advantage of behaviour change or 'secondary virginity' and the deferment of 'sexual adventurism.'[35] Zimbabwe does, however, accept that youth have the right to information and counselling services to prevent HIV/STIs. Youth are considered the highest priority group in the Mozambique Strategic Plan, including both in-school and out-of-school adolescents. Line ministries responsible for developing educational programmes and youth-friendly services include Youth and Sports, Education, and Health. Swaziland adopts a similar approach, promoting awareness among youth and promoting HIV/AIDS education in youth, sports and religious clubs. It also makes a bold commitment to integrating HIV/AIDS into the learning curricular of pre-schools, schools and institutions.

15. Research and Surveillance

Research, testing and monitoring are vital in the fight against HIV/AIDS. Lesotho, Mozambique, South Africa, Tanzania and Zimbabwe all address research in their policies, but with somewhat different approaches. Lesotho recognises the importance of it in the national response to HIV/AIDS and undertakes to create a favourable environment for research. It then outlines its protocols surrounding research ethics. HIV/AIDS-related research will require ethical clearance from the Lesotho AIDS Programme Co-ordinating Authority (LAPCA) and must conform to International Guidelines for Biomedical Research involving Human Subjects. All research will be co-ordinated by LAPCA and should include religious, socio-economic, behavioural and cultural surveillance. Governments will encourage partnership between local and international research institutions and will allocate resources for HIV/AIDS/STI research. The ethics of international research has been a contentious issue in Southern Africa, with some fearing that human subjects were being used as 'guinea pigs' for drug research that may ultimately be of no benefit to them.

Botswana stresses the importance of research and surveillance particularly in the areas of sentinel surveillance among pregnant women, STI surveillance and TB surveillance.

In South Africa's strategic plan "Research, Monitoring and Surveillance" is one of the country's four priority areas in its response to HIV/AIDS. Its research agenda goes much further than other SADC countries. As well as tackling standard issues such as surveillance and testing, the guidelines set out the necessity of developing a set of primary indicators to track the country's overall response to the epidemic. It also focuses on undertaking research for treatment for HIV and AIDS, including supporting efforts to develop a Clade C HIV vaccine, developing ethical guidelines for vaccine research, reviewing and revising policy on anti-retroviral and non-retroviral treatment and prophylaxis, and conducting research on the effectiveness of traditional medicines.

Tanzania's policy makes research one of its core strategies to achieving the AIDS programme's goal. It will support a research programme consistent with the overall goal

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[35] *National Policy on HIV/AIDS for the Republic of Zimbabwe.* Harare. December 1999, p. 24.

of the national strategic plan and indicates a need for a multi-disciplinary research effort by both national and international researchers. Research involving human subjects must respect rights of participants, including the 'rights to beneficence, veracity, justice and autonomy.' It goes on to lay down the organisational structure of AIDS research and research protocols. Ethical clearance will be subject to approval by the Chief Medical Officer.

One of Zimbabwe's core underlying principles is making research an integral part of its response to HIV/AIDS. To ensure effective delivery and maximise impact, monitoring and evaluation should included in of all programmes and projects.

The Mozambique strategic plan dedicates separate sections to research and to monitoring and evaluation. It calls for operations, biomedical and social research, including annual courses on research methodology; five studies a year on socio-economic impact; five studies a year on innovations in diagnosis, treatment and prevention; and 20 scholarships to attend international meetings. National numerical targets are set for activities and coverage; regional and provincial indicators are to be developed later. Two national fora to discuss results and a national impact survey are specified.

16. HIV/AIDS and Poverty

Poverty and HIV/AIDS are closely related. Unless poverty is addressed, AIDS can not be eradicated. Poverty dramatically increases vulnerability to HIV/AIDS. However, AIDS itself raises costs and devastates the economy. Lesotho, Malawi and Mozambique all make poverty eradication an integral part of their approach to controlling HIV/AIDS.

Lesotho does this by undertaking to meet its own, ambitious poverty eradication targets, the argument being that reducing absolute poverty will make people less physically and economically vulnerable to infection with HIV. Similarly, both Zimbabwe's and South Africa's strategy recognises that HIV/AIDS is closely linked to poverty and undertakes to establish poverty alleviation/income-generation projects.

Malawi has a slightly different approach, which is to identify and address 'disempowering' cultural, social and political norms, values and practices; to incorporate issues of gender equity in its public programmes; and to broaden the scope of organisations that target women, youth and other marginalised people. The Mozambique HIV/AIDS strategic plan is cited in the Ministry of Planning and Finance 'Absolute Poverty Reduction Action Plan (2000-2004).'[36]

Swaziland's strategic plan also includes a section on the 'social sector,' though it undertakes to support poverty alleviation initiatives as a way of mitigating the adverse effects of HIV/AIDS, rather than reducing vulnerability to it.

17. Orphans, Widows and Widowers

Orphans, widows and widowers are affected by HIV/AIDS particularly badly. The Malawi strategy recognises this and makes a series of recommendations to improve their care and support.   Recommendations include reviewing and enforcing laws that help to protect their interests and developing capacity to mobilise resources for their care and support.   South Africa plans to introduce measures that will facilitate adoption of AIDS orphans. It undertakes to investigate the use of welfare benefits to assist families living with HIV/AIDS and subsidising the adoption of benefits. Tanzania recognises the impact on widows and orphans, particularly in relation to property inheritance. The National AIDS Control Programme undertakes to educate communities at large on prevailing laws that concern the protection and legal rights of survivors regarding inheritance. It does not, however, offer more practical suggestions about how laws could be enforced. Swaziland's strategic plan suggests a numbers of strategies for ensuring that orphans have their basic needs met, including documenting and supporting existing programmes to provide models of best practice, instituting an orphan register and establishing orphans teams chaired by a representative of the Department of Social Welfare. In Botswana the Ministry of Local Government implements programs for orphan support.

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[36] *Absolute Poverty Reduction Action Plan (2000-2004).* Maputo. 2000, pp. 26, 37-38.

18. Culture

HIV/AIDS touches upon extremely sensitive issues surrounding culture, sexuality and religious belief. Some cultural practices in Southern Africa increase risk of HIV transmission. However, religious and cultural networks are also an important potential resource in sharing information and influencing attitudes and behaviour.

Lesotho's policy framework states that current scientific knowledge that respects human rights should take cognisance of 'social, cultural and religious worlds of meaning of the people of Lesotho.'[37]   The section on information and communication stresses 'traditional values' in promoting positive and responsible sexual behaviour. It also states that the cultural practices of scarification, habitual blade sharing, polygamy and wife inheritance have contributed to the escalating problem of HIV/AIDS and that IEC campaigns should be carried out, 'while we stay culturally sensitive.'[38]

The Malawi strategy makes an interesting contribution to the debates surrounding culture and HIV/AIDS. It undertakes to review training curricula for initiation rites, including putting more emphasis on moral training and self-protection, in collaboration with traditional leaders and counsellors. Traditional leaders are an important and influential group in Southern Africa. Allowing them to participate fully in developing ways of controlling HIV/AIDS is likely to make interventions more effective. Mozambique's strategic plan recognises the importance of cultural differences and calls for developing IEC materials in local indigenous languages. Swaziland's strategic plan places great emphasis on working with traditional healers and community leaders, undertaking to target chiefdoms with HIV/AIDS advocacy packages, strengthening traditional health care and support systems, and developing referral system between traditional and modern health systems.

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[37] *Policy Framework in HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 5.
[38] *Policy Framework in HIV/AIDS Prevention and Management.* Lesotho. September 2000, p. 17.

IV. Response by Sector

The HIV/AIDS epidemic undermines social and economic progress at *all* levels of society, presenting obstacles to the realisation of global development goals, and necessitating a multi-sectoral, multi-level response. The participation and coordination of multiple ministries and sectors (as well as the private sector, civil society, PLWHA, non-governmental and community and faith-based organisations, academic/research institutions, and international donor organisations) are fundamental to the kind of distributive leadership and integrated response to HIV/AIDS characteristic of a strongly committed multi-sectoral approach (as described in Section 2 above). This section considers existing HIV/AIDS-specific policies and programmes contributing to national HIV/AIDS strategic plans, available from specific government sectors, as summarised in the following table. Sector-specific policies were reviewed for eight of 14 countries within SADC. Where information was available, the review highlights the political commitment shown by faith-based organisations, traditional and community-based leaders, and the private sector (i.e., business, organised labour, the insurance industry, etc.).

Table 2. Sector Policies on HIV/AIDS

Sector	Angola	Botswana	DR Congo	Lesotho	Malawi	Mauritius	Mozambique	Namibia	Seychelles	South Africa	Swaziland	Tanzania	Zambia	Zimbabwe
Agriculture				X				I		W		X	I	
Culture, Information and Sports				I	I		X	I		W			X	
Education				X	X			I		X		X	X	X
Finance and Economic Planning								I		W		X	W	
Health/ Public Health				X	X			I		W	X	X	X	X
Human Resources				W									W	
Labour and Employment				W				W		W		X	W	X
Minerals and Energy								I		W		X	W	
Tourism					X			I		W		X	I	
Trade and Industry					W			I				X	W	
Transport and Works				I				I		W		X	W	
Uniformed Services and Police				X				I		W		X	I	

Key: X = either partial or comprehensive HIV/AIDS policy or programme in place and
  being implemented
  I = HIV/AIDS policy or programme in initial planning stages
  W = workplace-specific HIV/AIDS policy or programme *only*

Ideally, a comprehensive national response to HIV/AIDS involves analysis of the impact of the epidemic by key ministries and sectors so that each sector can address this impact in their plans for programmatic responses on many fronts (e.g., through health facilities, in the workplace, in correctional facilities, through media campaigns and targeted outreach efforts, through schools, etc.). In this way, the capacity of each sector in terms of resources and reach can contribute to an integrated response to HIV

prevention, care, and impact alleviation. The challenge for a well-coordinated national strategy is to develop sector-specific (workplace-specific) HIV/AIDS programmes that *also* augment the approach across.

The decline in HIV infection singularly experienced by Uganda has been attributed to the adoption of this kind of integrated, multi-sectoral approach. The Uganda AIDS Commission coordinated efforts and developed interactive implementation systems between the national secretariat and ministries, districts, and village councils in order to decentralise responsibility and resources (both human and financial) to the community level. This approach included building partnerships with PLWHA, religious groups, academics and researchers, the media, the private sector, unions, workers, employers, herbalists and traditional practitioners, and NGOs. Technical committees were organised to coordinate efforts in research and development, prevention and control, care and support, and policy and ethics to build consensus and mobilise resources in a coordinated fashion *across* all sectors.

The sustained development of HIV/AIDS-related health and social services through a multi-sectoral approach is a key goal of the United Nations' Millennium Summit (September 2000) and special session on Copenhagen +5 (July 2000). UN resolutions encompass education and prevention programmes and services, care (including prenatal care), access to affordable medications and other pharmaceutical agents, and support for PLWHA, including home-based care, family planning programmes and the empowerment of women. They emphasise the need to integrate HIV/AIDS concerns in *all* development assistance programmes and poverty reduction strategies, and 'to ensure the development and implementation of multi-sectoral, national strategies and financing plans' to assure the most efficient and effective use of resources allocated. Multi- and cross-sectoral approaches emphasise the involvement of a broad range of players and encourage viable public-private partnerships.

1. *Integrated National HIV/AIDS Responses*

Whereas all national policies of the countries within the SADC region promote multi-sectoralism and many of the countries have employed broad-based consultative processes to develop national HIV/AIDS policies, there is considerable variety in the way this approach is both financed and operationalised and in which sectors play lead roles

across the region. National coordination of a multi-sectoral approach includes processes and systems for coordinated planning and technical assistance, as well as budget allocations for participating sectors; it also involves monitoring and evaluation of individual and joint programmes towards the accomplishment of mutually agreed upon results.

The range is considerable across the SADC region. For instance, the government of Lesotho has a multi-sectoral strategy and policy document in place, and all ministries and various private sector and parastatal companies have HIV/AIDS focal points. National coordination is provided by a newly-appointed Chief Executive of the Lesotho AIDS Programme Coordination Authority, placed within the Prime Minister's Office. Whereas governmental support is significant in that 2% of each ministerial budget is allocated to HIV/AIDS/STIs, current activities are primarily IEC-focused and technical assistance is needed to translate the national plan into coherent sector plans.

The United Republic of Tanzania's Ministry of Health issued National Multisectoral Policy Guidelines on HIV/AIDS/STIs that underline the importance of sector resource mobilisation, given its dependence on external funding for control of the epidemic. South Africa's 2000-2005 National HIV/AIDS Strategic Plan also calls for broad involvement of all sectors of society. Most importantly, relevant national and provincial structures have been developed (e.g., an Inter-Ministerial Committee on AIDS, an Inter-Departmental Committee on AIDS) to systematically implement the national programme and cross-sectoral response. Many national departments and such ministries as the Ministry of Public Service and Administration and the Ministry of Safety and Security are now developing HIV/AIDS policies in alignment with this overarching national strategic plan. Similarly, the Republic of Namibia convened a Multi-sectoral Committee in 1998-1999 to develop the Medium Term Plan II that contains appendices outlining sector-specific obligations to achieve the expanded national HIV/AIDS response. As a result of active stakeholder analysis and coordinated multi-sectoral planning, the National AIDS Committee (NAC) was elevated and restructured and a National Multi-sectoral AIDS Committee (NAMACOC) was established in Namibia so that management of the epidemic through the NAC is now placed outside of the health sector's more limited scope. Each sector has specific, detailed responsibilities, target audiences, resource allocations, and key partners and is obliged to submit progress reports to the NAC so

that mutually agreed upon national objectives are met in a coordinated fashion. Multi-sectoralism is reflected infrastructurally from the NAC level (whose cabinet members represent all major sectors) to NAMACOC (whose membership includes cross-sector ministers, UN Theme Group delegates, major NGO representatives, private sector representatives, parastatals, and regional governor's officers) to multi-sectoral Regional AIDS Committees. The Ministry of Health is charged with providing technical assistance upon request to all sectors to coordinate technical implementation of the national plan and evaluate impact. The Office of the Auditor General is charged with evaluating the national response in relation to expenditures and fund utilisation.

Structure follows function. For this reason, there is tremendous variation in the degree of integration of HIV/AIDS plans and activities even among those countries with similarly designed multi-sectoral coordinating bodies. In contrast to mainland Southern Africa where in seven countries at least one in five adults is living with HIV, the epidemic is currently progressing more slowly in Mauritius and Seychelles. Mauritius was able to establish a National AIDS Control Programme in advance of the first reported AIDS case; cross-sectoral agencies were able to collaborate early on to generate an environment conducive to HIV/AIDS control.

Evaluation of the second Medium Term Plan (1994-1998) in Zambia identified the lack of strategic management and political guidance for macro-economic policies related to HIV/AIDS. The response, in the HIV/AIDS/STD/TB Strategic Framework for 2001-2003, established a Committee of Ministers 'to sustain advocacy…political will…and political guidance', and a National HIV/AIDS/STD/TB Council with corresponding Secretariat to coordinate implementation among 14 ministries, NGOs, CBOs and private businesses. 'Catalytic projects,' intended to expand localised best practices to national scale, are considered a priority step towards achieving mobilisation of a multisectoral response; each project is the responsibility of a specific line ministry, with oversight and coordination provided by the National AIDS Council and Secretariat. As there is evidence of overlap and redundancy among the 42 projects, decision-makers developed a 'Decision Matrix for AIDS Investments,' including such parameters as cost effectiveness and humanitarian concern to prioritise scale-up activities and interventions. Nine different working groups are overseeing implementation of a range of initiatives, including expansion of VCT, development of frameworks within which to conduct vaccine

trials, development of a national framework for support to orphans and vulnerable children, and development of a proposal to allow the Zambian government to use national funds earmarked for the servicing of debt to support the public sector. The impetus for integrated, national strategic priorities is likewise reflected in administrative structure. For instance, the Programme Section of the National HIV/AIDS/STD/TB Secretariat is organised into Prevention Care and Support, Impact Mitigation, Liaison, and IEC units that functionally operationalise coordination of a multisectoral approach during this scale-up period.

Also included in the sets of Zambian national directives are more specific operational policies that provide an institutional framework for cross-cutting issues related to HIV/AIDS, such as gender issues and standards for prevention counselling. In 1996, the Cabinet established a Gender in Development Division to implement the National Gender Policy through a Gender Consultative Forum and line ministry and provincial focal points. In this way, HIV/AIDS issues are to be integrated across gender, adolescent health, reproductive health, and nutritional programmes for women, including the goal to specifically encourage men to become involved in caring for those with HIV/AIDS. Recognising that interpersonal risk-reduction counselling is fundamental to health promotion and prevention efforts, the Zambian National AIDS Prevention and Control Programme (with SIDA funding) developed a 'Code of Ethics and Practice for Counselling in Zambia' to establish standards of competence and conduct (such as ensuring voluntary consent and confidentiality) for practicing counsellors, counselling trainers, and supervisors during pre- and post-test counselling, and preventive and support counselling. Evaluation of standards and of the degree of capacity building is built in to the standards for management and employee review. These directives are reinforced through a more detailed set of 'Guidelines on HIV/AIDS Counselling in Zambia,' produced by the Ministry of Health in 2000, that outlines implementation and enforcement of HIV/AIDS counselling policy guidelines for specific client groups (e.g., women, couples, youth) and in specific settings (e.g., VCT).

As exemplified in Swaziland's (1998) policy document on HIV/AIDS/STD prevention and control, many countries in SADC are challenged to find effective ways to integrate and coordinate HIV plans and responses between governmental and non-governmental sectors. Similar to the management initiatives undertaken by Zambia, the multi-sectoral

national response in Swaziland requires strengthening of coordinating management structures at national and regional levels. While NGO and private sector representation is included within the overarching National AIDS Committee (which is answerable to the Cabinet), NGOs must independently locate resources (including leadership) with which to establish coordinating committees to facilitate their work and ensure that participation in strategic planning and implementation is 'bottom up,' not just directed from government-controlled agencies 'downward' to community-based groups. It is commendable that the policy in Swaziland includes NGOs in such bridging groups as the technical AIDS Task Force and planned, multi-sectoral regional committees. Yet policies might be more emphatic to ensure that persons living with HIV/AIDS are specifically included in decision-making at each level of the structure and that NGO contingencies are genuinely representative of the constituencies they serve.

In its call for highly visible leadership and commitment by all in the political, civil and business communities, the Zimbabwean National HIV/AIDS Strategic Framework (2000-2004) states that 'the response should therefore be multi-sectoral in approach while recognising that there is no homogeneity in the manner in which different populations respond and are affected by the disease.' The establishment of a National AIDS Council (NAC)/National AIDS Foundation to replace the National AIDS Coordination Programme represents expansion of responsibility to include overall leadership, policy direction, and guidance/coordination of the national response to HIV/AIDS. At the same time (1999), the government of Zimbabwe mobilised domestic resources by introducing an AIDS levy on all taxpayers; these funds were set aside to administer the national response through the NAC. The NAC's Board of Council includes representatives from the Traditional Medical Practitioners Council, the Law Society of Zimbabwe, and representatives of health care providers, women, youth, religious groups, organisations that protect the interests of persons with HIV/AIDS, industry, commerce, information media, and trade unions. A composite (national) budget was developed within the strategic HIV/AIDS framework in order to align resource provision priorities and objectives of current and potential donors; this was then fit to sector-specific and level-specific operational strategies and plans, with a master timetable for achieving milestones across all levels. With its large numbers of persons infected and affected by HIV/AIDS, Zimbabwe's national response faces the dual challenges. It must create sustainable programmes that meet local needs despite being driven by multilateral or bilateral donors, and balance the

increasing demand for direct care services (which currently constitute approximately 60% of the national health budget, excluding antiretroviral therapy costs) with the ongoing need for HIV prevention and control. Further complicating the situation, churches, NGOs, political parties, donors and the private sector are all driven by different value systems that can give competing signals to society and even undermine the work being done by different sectors.

SADC has assisted the process of developing multi-sectoral responses by developing regional plans. For example, the ministers of Culture, Information and Sport approved the HIV/AIDS Sectoral Plan at their meeting held in Lilongwe, Malawi in 2000.

2. *Integrated Local HIV/AIDS Responses*

As important as national prominence and resource allocation, local leadership and coordination through respective sector structures can more effectively channel sparse resources directly to key target groups during implementation of HIV/AIDS plans. In Tanzania, the multi-sectoral response is defined in literal terms of 'the spirit of community participation' throughout national and district strategic planning, fundraising, and implementation efforts; it also includes ward-level and village-level prevention, care and support programme planning. In some cases, local leaders and the private sector have responded even more quickly to HIV/AIDS than the non-health public sector. In Lesotho, eight of 10 districts established District Multi-sectoral Taskforces, including officers from the private sector, churches, NGOs, and clubs. These taskforces were responsive to HIV/AIDS-related issues in the community, even before a national strategic plan was developed. They served variously as prevention communication channels to sector-specific clients/audiences, as referral points to healthcare, as focal points for development of community-level support groups, as providers of foster care and orphan care, and as fundraisers. Most encouraging, one district's multi-sectoral, non-profit taskforce facilitated the allocation of land by chiefs for household food security to HIV-affected families, clearly a local issue.

In Zimbabwe, the strategic framework describes a consultative process for creation of a coordinating structure from national to grassroots levels. It specifies as a priority the 'institution of HIV/AIDS programmes in the work places which could be the subject of inspection by the health department of any local authority.' To date, the local

government sector has responded mainly through schools and the clinical services of health institutions and is notably not well integrated into the national response at the political level. There is a need in Zimbabwe to re-capitalise and revamp the public welfare assistance system to provide a safety net for those HIV-infected persons in greatest need, since the private sector has frequently filled gaps in health and other services. Remarkable progress has been made in recruiting key (male) influential leaders for such local efforts as home-based care groups; the changes in social behaviour and attitudes requisite to involvement of men in patient care constitute a cultural breakthrough. Yet the general issue of over-reliance on voluntarism in the (local) NGO, CBO and community sector, after so many years of volunteer effort against the epidemic in Zimbabwe, highlights the need for a coherent, planned system for service delivery at this level. There are plans to develop a national strategy to promote and manage voluntarism and to study and strengthen the state of the art of community-based responses.

In building a multi-sectoral approach, an entire organisation or ministry may not be involved in HIV/AIDS-specific activities at first so much as a department or unit. With deliberate and concerted planning, an accelerated effort can be put into a number of critical lead sectors beyond the initiatives taken by health/public health and education sectors. With increasing political commitment, the experience of some countries within SADC is that national HIV/AIDS programmes typically evolve through a restructuring process that elevates them to the highest policy-formulating authority (i.e., at the Cabinet level) and next-round medium term plans become frameworks for developing integrated plans of action by participating governmental, non-governmental and private sectors. For instance, in Lesotho, while the only comprehensive strategic plans to date are those of the ministries of Education and Agriculture, an accelerating number of draft HIV/AIDS strategies are being issued by the Ministry of Justice, the Ministry of Home Affairs, the Ministry of Works and Transport, and the Lesotho Highlands Development Authority. In Tanzania, the challenge of implementing such a multi-sectoral response is described in terms of strengthening management; technical capacity of national, district and sector institutions; resource mobilisation; disease surveillance; research; and collaborative multi-sectoral and multi-district planning. A major outcome of joint planning among participants from a cross-section of NGOs, government ministries, various sectors including those of religion, district representatives and donors has been the rank-

ordering of determinants of the epidemic in Tanzania in order to prioritise joint programme objectives. Different sectors then established technical AIDS committees (TACs) to implement and monitor HIV/AIDS activities within specific priority areas. Implementation is decentralised, occurring in concert with district and local governments, while national government resources are used for support of human resources development, establishment of management information systems, and capacity building through TACs across sectors.

Legal Frameworks

In some instances, programmes that are controversial even in the health arena are able to be expanded through other sectors only with the sanction of law. For example, the South African Law Commission issued two interim reports on aspects of law relating to HIV/AIDS and discrimination in schools and pre-employment HIV testing. And the HIV/AIDS/STD workplace policy for the Department of Provincial and Local Government in South Africa cites the Constitution Section 27(1)(a), providing for the right to have access to 'reproductive health care' in order to distribute condoms and to promote social norms against sexual abuse and violence as part of HIV prevention programming. Various South African National Department HIV/AIDS policies rely on the Occupational Health and Safety Act No. 85 (1993) and the Compensation for Occupational Injuries and Diseases Act No. 130 (1993) as precedents for the establishment of safe working environments that include universal precautions. Under these guidelines, possible exposure to HIV instigates baseline HIV testing and re-testing three and six months later, and seroconversion entitles the HIV-infected employee to apply for compensation. The Namibia Ministry of Labour issued HIV/AIDS guidelines in 1998 that progressively recast AIDS from a medical problem to a development problem affecting all sectors, linking 'the fundamental principles of human rights embodied in the Constitution of the Republic of Namibia, the provisions of the Labour Act (Act No. 6 of 1992), occupational health principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals.'

Tanzania's National Multisectoral Policy Guidelines on HIV/AIDS/STIs explicitly state the need for a legal framework in which to effect implementation. Legal issues here include the need to amend inheritance laws, provisions in the penal code and Sexual Offences Provision Act for wilful spread of HIV, legislation to define age limits for 'orphans,' and

specific legislation to provide for the autonomy and legal status of the National AIDS Control Programme. Other countries, such as Zimbabwe, are also debating a proposed Sexual Offences Bill and are wary about establishing evidence determining blame of a particular individual in issues of purposeful infection. The Sexual Offences Bill of 2000 seeks to protect minors and mentally handicapped persons 'from sexual predation,' punish certain non-consensual sexual acts, combat prostitution, punish the deliberate transmission of HIV/AIDS, and provide for compulsory testing of sexual offenders. There is also heightened concern that clandestine demands for disclosure of HIV status compromise the right to confidentiality of those who are affected; areas of insurance, pensions, occupation, and so forth remain a challenge in balancing protection of interests/rights for infected, affected, and unaffected persons. The Zimbabwean National HIV/AIDS Policy (1999) specifically states that 'because of the stigma still attached to HIV/AIDS, the rights of PLWHA need special consideration.' By promoting and widely publicising the Patients' Charter, PLWHA are educated about their rights.

The health-specific and multi-sectoral policies and plans for most countries in the region lay out, in principle, 'support' for the human rights of people living with HIV/AIDS. Yet most do not delineate how such goals as 'no stigmatization on the basis of their HIV status' or 'protection of privacy, employment, education and housing irrespective of HIV status' can be achieved and monitored. Mauritius has attempted to institutionalise an ethical code (concerning human rights issues for people with HIV/AIDS and for care providers) by publishing a manual on medical and ethical management and counselling for health care workers.

Proposed or existent human rights legislation does not always extend to protection of sexual identity. For instance, a legislative work plan for the Multi-sectoral Technical Advisory Committee in Mauritius stipulates 'specific policy on homosexuality and education on HIV/AIDS and the proper use of condoms' without making clear the direction or the goals of the policy (i.e., to protect or to sanction?).

3. Sector-specific Issues

Agriculture Sector

Whereas most sector HIV/AIDS strategies include an IEC component, they do not always include a behaviour change programme for step-wise risk assessment/risk reduction or for delivery of prevention programmes to different target audiences at village-to-national levels. In Lesotho, the (draft) HIV/AIDS Strategic Plan of the Ministry of Agriculture and Marketing recognises the importance of targeted communication channels (e.g., for personnel, youth farmers, herd boys, agriculture association members) and reinforced behaviour change messages via HIV/AIDS radio broadcasts, competitions, public gatherings of extension workers, and district and central agricultural shows.

In South Africa, the Department of Water Affairs and Forestry is integrating the health risks associated with consumption of contaminated water by HIV-infected persons (i.e., regarding water-borne diseases such as cholera, bilharzia, and malaria) into community awareness programmes. In Zambia, the Ministry of Agriculture, Food and Fisheries' (MAFF) HIV/AIDS workplan for 2001 includes a behavioural survey of the fishing community and use of participatory extension approaches to promote HIV interventions. In conjunction with the National AIDS Council, MAFF is developing and producing an HIV/AIDS handbook for its over 80 district/provincial focal points; more specific risk reduction objectives and final target audiences are not described, and it is not clear how these workplace-specific objectives will be monitored as an integral part of the overall national response.

Malawi's Rural AIDS Initiative (RAID) represents a major effort to mainstream HIV/AIDS prevention and mitigation in a widely decentralised project process that engages rural communities and workplaces. The initiative is carried out on a number of levels, including policy support, field support, and field operation through rural development management teams. The government of Malawi in the course of development of its sector-specific response has identified a number of major challenges:

- To reduce HIV infection rates for farmers, agricultural staff and other rural development agents (87% of whom are women engaged in subsistence agriculture);

- To reduce the adverse effects from HIV/AIDS on the agriculture sector (i.e., it is estimated that HIV/AIDS decreases agricultural production by 30%);
- To integrate HIV/AIDS within poverty reduction and development strategies in a way that maximises the results of impact studies and best practices.

The 2000-2004 Strategic Plan for the Agriculture Sector in Malawi identifies 'inadequate functional linkages laterally and vertically,' 'no clear budget lines and strategies,' and 'inadequate and unclear strategies for scaling up HIV/AIDS prevention and mitigation in rural communities.' It is proving to be a tremendous undertaking to re-orient the current planning and operational structures to factor in and link HIV/AIDS activities. And there is recognition in the rural sector strategy of the trade-offs between coverage and quality of service.

The HIV/AIDS Strategic Plan in Malawi outlines a number of useful approaches for mainstreaming the (agriculture) sector response to HIV/AIDS within ongoing rural development projects aimed at poverty reduction.   The following mainstreaming principles are applied through a gender-based participatory development, multi-sectoral, decentralised approach with 'bottom-up/top-down' strategies:
- Mainstreaming policy documents;
- Responding based on impact of the HIV epidemic on the agriculture sector's 'core functions' and at national, community, household, and individual levels;
- Integrating HIV into the sector's 'core business' of rural development partners and measuring potential impact by including the implications of HIV/AIDS in ongoing rural appraisals and cost-benefit analyses; and
- Using 'strategic entry points' (i.e., policy, institutional structure and process, key stakeholders) to mainstream issues of HIV at every phase of programming in order to foster society-wide behaviour change.

Culture, Information and Sports Sector

Government sectors infrequently include fundraising as part of community outreach and support programmes.   In South Africa, the HIV/AIDS policy of the Government Communication and Information System is distinctive in its commitment to organise

annual AIDS fundraising activities 'in aid of hospice care of people in the terminal stages of AIDS.'

The broader approach taken by the Republic of Namibia's Ministry of Information and Broadcasting is to ensure the implementation of the national IEC action plan on HIV/AIDS *across* all sectors in collaboration with private and general media communities. Standardisation and reinforcement of messages is thereby controlled through the ministry's technical assistance efforts, including compilation of inventory lists of each sector's activities. In this way, the ministry facilitates planned information dissemination to a wider array of target audiences and guarantees regular coverage of HIV/AIDS issues in print, radio, and TV media.

In Zambia, the Ministry of Information and Broadcasting Service (with World Bank funding) is producing HIV-related mass media campaigns and providing condom distribution; documentaries and radio programmes produced by the ministry are intended to reach to all urban and rural populations by 2005. Such workplace-specific activities as training focal point persons and peer educators are actually implemented through the collaboration of Central Boards of Health with private counselling services. The ministry is also training peer educators/counsellors and forming employee support groups to explore 'different options they can take to reduce their vulnerability and thus be able to extend their experiences to communities.' It collaborates with the Ministry of Sports, Youth and Child Development to reach out-of-school youth through a network of 15 Youth Resource Centres, and it engages high profile sportsmen and women to conduct public seminars on HIV/AIDS issues.

Education Sector

Most education sector policies reviewed contain detailed HIV/AIDS programmes (sometimes including protective skills-building, life skills education, and safer sex/sexuality education) for current students and teachers but rarely include plans for future school-age populations and teacher cadres that might be impacted by the epidemic. These policies describe the impact of HIV/AIDS to school-aged children in terms of psychosocial distress, increased malnutrition and reduced learning capacity, loss of school-based health care that includes opportunities for immunisations,

homelessness and crime. In Lesotho, the strategic plan of the Ministry of Education describes a comprehensive, participatory approach to HIV/AIDS prevention in primary education, including the formation of a HIV/AIDS Educational Taskforce to steer IEC and service delivery through formal and non-formal education, curriculum development and training channels with resource sharing among specific organisational partners. It also recognises the importance of impact assessment on teachers, administrators, pupils and parents and specifically states the need 'to initiate long-term interventions for special focus groups including children with HIV/AIDS, AIDS orphans...'

The education sector in Malawi recognises the central importance of education, guidance, and counselling in building a social environment that is stigma-free, in promoting HIV prevention messages, and in trying to reach school drop outs. The plan to introduce HIV VCT services (for both teachers and students) is coupled with such mechanisms as partnerships with NGOs, community, orphan programmes, and government ministries; promotion of HIV risk-free extracurricular activities; and establishment of a comprehensive HIV prevention policy framework that also incorporates issues of gender equity and equality. HIV interventions are also incorporated into the Ministry of Labour and Vocational Training curriculum for education and skill-building persons in different trades. A number of challenges are identified, given that many HIV interventions are cross-cutting and require that activities be accomplished coincidentally and with the involvement of every sector simultaneously:

- Research is the underpinning of the strategic response to HIV, given the complex interplay of biomedical, social, cultural, economic, human rights, legal and ethical issues.
- Progress monitoring and evaluation need to be accomplished using appropriate (pre-set) indicators.
- Prioritising actions within and between activities (e.g., curricula development, teacher training, human resource management, etc. all have possible outputs that are possible inputs of other activities) is critical to redirecting resources and to achieving tangible outcomes with a minimum of repetition and oversight.
- Local resources (and participatory community-based initiatives) must be mobilised in order to meet both short-term and long-term objectives in a sustainable manner.

The South Africa Ministry of Education's HIV/AIDS policy defers HIV/AIDS education in secondary grades to 'guidance counsellors' and issues of condom distribution through schools and learning institutions for determination through 'community decision-making processes.' This policy allows for the interpretation of the national policy and adoption of local implementation plans 'to give operational effect to the national policy,' including 'discretion regarding mandatory sexuality education, or whether condoms need to be made accessible within a school or institution as a preventive measure.' In May 2001, the Associated Press reported the South Africa Education Minister's speech to Parliament, describing that 'a national plan will be developed to adapt the education management system to the epidemic.' Components of the new plan include a national conference on sexuality in education (with emphasis on HIV/AIDS), addressing the special needs of HIV-infected students, and responding to the needs of the increasing numbers of children orphaned by the disease.

Recognising that between 10,000 and 12,000 children fail to complete school (i.e., 'drop out') and that this group often adopts HIV risk-associated behaviours, the Ministry of Education in Mauritius is implementing a series of interventions aimed at empowering these youth to adopt safe lifestyles. Notably, the project is implemented collaboratively among many players, including the Ministry of Health and NGOs. Given that 16% of HIV infections are reported among 15-24 year olds (who acquired the virus years earlier), the National Youth Policy on sex education needs to be expanded beyond its current coverage of only those aged above 15 years.

Cross-cutting gender issues are also being addressed in South Africa. In October 1999, the Ministry of Education, Sport and Culture released a circular providing leaves of absence for pregnant female students (and requiring expulsion of male students responsible for these pregnancies for the same period of time). Re-enrolment of female students is seen as fundamental to their increased economic empowerment. In January 2001, the ministry also released a circular mandating HIV/AIDS education in primary and secondary schools, with minimum time allocations specified at each grade level.

Zambia's draft School Health and Nutrition Policy (1999) reports that the Ministry of Education is 'being crippled by high death rates among teachers' and that Provincial Education Officers are complaining that their budgetary allocations are being exceeded

due to a large margin for coffins and funerals from high death rates among teachers. The Ministry of Education is involved in a range of local and national-level HIV/AIDS activities through its network of schools and 23 collaborating training institutions of the Ministry of Science, Technology and Vocational Training. Major sector-specific activities are training-of-trainers/lecturers, promoting STD/HIV/AIDS and drug/alcohol abuse prevention through anti-AIDS clubs, and integrating life skills and HIV prevention into curricula and parent education. After considerable debate, the Ministry of Education decided to use a 'carrier subject approach' to deliver compulsory, examinable comprehensive HIV/AIDS education/counselling, behaviour change strategies, and non-discriminatory attitudinal change learning (though it is not clear at which grades HIV-related subjects are introduced). This approach uses such subjects as health education as 'carriers' for all cross-cutting issues faced by children in the country (i.e., HIV/AIDS, drug and alcohol abuse, human rights, gender and equity, environmental health, life skills, and population and family life education). Cross-sector activities include the ministry's participation in development of a national policy on HIV/AIDS and orphans, strengthening the bursary schemes for care of orphans in collaboration with the Ministry of Community Development and Social Services, and adopting a child-to-child programme of health information for in- and out-of-school youth as an extension of the school health services provided by the Ministry of Health. However, Zambia has no effective legislation in regards to children and young people; an effort is underway, involving a wide range of ministries and agencies, to establish a juvenile justice system and care provision for youth at risk, street children, and delinquent youth. Another challenge facing the Ministry of Sports, Youth, Child and Development is to ensure gender balanced enrolment in Youth Skills Training Centres and in recruitment of youth development officers, instructors and programme officers, as well as gender balance at senior levels within the ministry itself.

Finance and Economic Planning Sector

The Republic of Namibia's HIV/AIDS Medium Term Plan II obligates the Finance, Treasury and Resources sector to mobilise and allocate resources for HIV/AIDS-related interventions to respective sectors, as well as specifying sector-specific objectives. In addition to ministry-specific prevention and condom distribution programmes, this sector

is to ensure that *all* sectors allocate a set percent from their budgets for HIV/AIDS-related activities.

In Zambia, the Ministry of Finance and Economic Development has issued a 2001 workplace-specific plan for designating focal point persons, developing a HIV/AIDS information desk in the ministry, and establishing counselling and home-based care activities (though service recipients are not defined). But it is unclear whether there are sufficient funds to support direct services, or whether services will be provided indirectly through less-costly referrals. And compared to the Zambia Revenue Authority's HIV/AIDS policy, the plan does not establish goals for supportive workplace environments and non-discriminatory policies that go beyond information sharing to build comprehensive workplace programmes with VCT and HIV/AIDS training integrated into ongoing orientation.

Health/Public Health Sector

The persistence of the epidemic in the SADC region has resulted in an accelerated search for operative public health practices to prevent further transmission of HIV/AIDS/STIs, which is most often the purview of the Ministry of Health. This sector's wide scope of responsibility typically spans such HIV/AIDS programme areas as research and dissemination of scientific information; training of medical and paramedical personnel; surveillance; prevention; counselling, testing, and social support services; provision of primary health and medical care through improved health care systems; and implementation of health aspects of HIV/AIDS/STI programmes. These sector policy documents uniformly speak to the importance of equitable access to quality services, yet none specify indicators to ascertain minimum standards in these areas. And in view of the widely reported condom shortages in the region, it is difficult to know what portion of resources will be allocated for each programme area. With increasing sector participation, another issue is that of shifts in government budgets for AIDS-related activities once solely promulgated through the health sector (and increased competition for limited resources focused on prevention, care and support).

As ministries of health grapple with decentralisation of medical and preventive services for other diseases, they often pave the way for local multi-sectoral approaches to

HIV/AIDS, addressed as a sustainable community development issue. For instance, in Tanzania, the Ministry of Health established procedures for multisectoral collaboration through Primary Health Care Committees involving agriculture, water, education, community development, political parties, religious organisations and other charitable organisations, and private individuals to coordinate health development programmes at different levels. Special health issues which also pose a risk of HIV infection, such as the practice of female genital mutilation, early pregnancy with large age differentials between spouses, sexual abuse and drug abuse are being addressed on multiple levels by the Ministry of Health in collaboration with the Ministry of Community Development, Women Affairs and Children, and the Ministry of Labour and Youth Development. The Ministry of Education has long been a primary partner through the School Health Programme in Tanzania, as has been the Ministry of Agriculture through the Tanzania Food and Nutrition Centres. There is also a long history of collaboration between the government of Tanzania and various missionary organisations and parastatal organisations (e.g., the sugar industries) to provide services through the privately-owned hospitals (which constitute about 50% of all hospitals in the country). HIV/AIDS health care services can easily be added to the agenda of such collaborative cross-sector programmes. Yet the problem of insufficient government resources for health and community services remains, largely as a function of increasing international debt burdens; this makes a coordinated multi-sectoral approach a requisite for the efficient use of limited resources.

The Ministry of Health in Zambia has been addressing biases in the health service infrastructure system in two ways: by attempting to correct the balance between predominantly curative services and preventative services, and by ensuring coverage of rural populations rather than reliance on centralised services for urban populations. At the end of 1991, the Ministry of Health Planning Unit issued 'National Health Policies and Strategies,' adopting primary health care as the most appropriate approach for accomplishing overall health reform. A variety of new management initiatives were undertaken, including the introduction of health goals-oriented planning, the establishment of autonomous district health boards and area boards of health, and provisions to build technical capacity of basic health programmes to enable a core strategy of managing for quality through the district health management system. The Zambia Ministry of Health recognised that knowledge of AIDS was nearly universal

(though knowledge of STIs less so), and while over 90% of the Zambian population believes that AIDS is avoidable and knows how to avoid it, most men (57%) and women (45%) still do not believe themselves to be at risk, though one in five adults is currently HIV infected. Given this fact, reduction of HIV/AIDS morbidity and mortality began to be evaluated in terms of the achievement of such guiding principles as quality technical guidance, intersectoral collaboration, and decentralised delivery of promotive and preventive services. Cross-sector groups including commerce and industry groups were organised, such as the Interagency Technical Committee on Population and Development, the All Party-Parliament Group on Population and Development, the National Blood Transfusion Advisory Board, and the Inter-Ministerial Coordinating Committee on Youth. And sets of mutually reinforcing programme policies were developed. For example, the Reproductive Health Policy (2000) addresses the need to provide logistical and financial resources for HIV/AIDS programmes at both national and community levels and advocates for availability of a continuous supply of affordable drugs and alternative therapies to HIV/AIDS clients. The Health Education and Health Promotion Policy (2001) carries out decentralised health care reform (on issues of HIV/AIDS/STD/TB/Leprosy) through policy development and technical communication skills-building work in liaison with Central Boards of Health, and provincial and district health offices. The National Policy on Breast-feeding Practices, a collaborative product of the Ministry of Health and the National Food and Nutrition Commission, addresses issues of post-natal transmission of HIV through breast-feeding, provides for VCT in maternal and child health settings, and promotes optimal infant feeding practices for HIV positive mothers (and their partners). Finally, the Integrated Reproductive Health (IRH) Plan of Action (2000) implies that all clients have access to reproductive health services (including HIV/AIDS and STI treatment/contact tracing services) on all levels of the health care system, on all days, during the same visit, and where possible by the same provider. Yet there are still reports of the limited availability of VCT services, primarily through private providers, NGO and church health facilities, and some hospitals which too frequently serve as health centres. And many IEC activities continue to be carried out as isolated projects without an adequate institutional base.

IEC programmes to 'ensure that accurate messages, appropriate for the general population and specific target groups, are provided' are central to the health sector prevention response in Swaziland. Though it should be noted that this information is

obtained from a 1998 policy document that may have undergone revision, the issue of how to best motivate and ensure long-term behaviour change and human rights promotion may not be adequately addressed through IEC-only campaigns. All countries are still challenged with how to build comprehensive responses in terms of content, scope, and balance of prevention/care programming. As acknowledged in Swaziland's policy, 'assistance (including provision of drugs to treat opportunistic infections associated with AIDS) will be provided to the extent that prevailing economic conditions and social structures will allow…' Those same resource limitations apply to the challenge of disseminating, operationalising, and enforcing policies (e.g., the broad goals for condom promotion, protecting the blood supply, expanding sexual and reproductive health services to youth, etc.). It is noteworthy that Swaziland addresses those resource concerns by envisioning NGO and non-health sector involvement during design and implementation of such activities as social marketing. It is also significant that the national policy promotes home-based care and the involvement and education of family members as potential care providers.

Recognising that policy-makers, hospitals, care providers, and rural health motivators had no HIV or TB management guidelines, Swaziland's National AIDS Programme drafted guidelines to standardise the diagnosis, admission and discharge, care and management of HIV/AIDS patients (in hospital, community, and home environments), in collaboration with the World Health Organisation. As is true in many other SADC countries, hospital wards are mostly occupied by patients who have HIV-related diseases and TB (one of the most common opportunistic infections, others of which include candidiasis, dermatitis, herpes zoster and other fungal infections). Some of the problems inherent to care and treatment in Swaziland that are generalisable include the following:

- Quality of care varies widely among hospitals, health centres, and clinics and there is no standardised institutional policy (and no AIDS care and management teams) for quality of care along a continuum from diagnosis to discharge and referral.
- Many regional hospitals do not have HIV rapid or ELISA testing facilities and inadequate or no counselling services, and in those instances in which blood samples are sent to the central laboratory, HIV test results are not typically

available for 3-5 weeks, resulting in loss to follow-up. Most TB patients do not receive testing for HIV.

- Few health services provide discharge plans or follow-up care plans, and there is a scarcity of community home-based care programmes.

- Out-patient care services are fragmented; home-visit programmes are evident usually only in private sector and religious mission health services.

- Directly observed treatment (DOTS) programmes are not available for TB patients. There is great variation in how TB patients are treated, and diagnosis is usually clinical rather than laboratory result-based.

- Counsellors, even nurse counsellors, are not seen as essential members of AIDS care and management teams – lack of counselling services has many consequences, including that mothers/parents of HIV-positive infants may not be informed of the nature of their child's illness.

It is notable that Swaziland's care and treatment guidelines stipulate ways to maintain confidentiality throughout the continuum of care-giving services and provide standard universal precautions for care providers. Counselling is identified as a core service: for risk-reduction planning, for pregnancy planning, for coping with the long-term nature of HIV-related illness, and to address issues of stigmatism, rejection, and moral judgment. The guidelines also point to the need for a national taskforce to consider such issues as anti-retroviral treatment of HIV-infected pregnant women to prevent MTCT. And particularly the Ministry of Information and Department of Social Welfare are called upon for a major role in increasing public awareness about issues related to care, such as the need for compassion for those affected and the need for community-support networks for PLWHA and their families.

Many HIV-related care issues are complex and require coordinated responses. Coordination of those responses becomes an issue that typically falls to government to address – through policy guidelines, databases for monitoring and evaluation, facilitation of coordinated strategic planning among multiple implementers, and coordinated resource mobilisation. In Malawi, policy guidelines to address the expected increase in orphans due to AIDS were established as early as 1992. The guidelines delineate the central role of the Ministry of Women and Children Affairs and regional and district social welfare systems in coordinating orphan programme development, reinforcing this system

and building on the existing foster care system (and extended family systems) in Malawi. It poses a significant challenge to liaise with the NGO community, religious organisations, self-help groups and charities, and extended families in order to meet the basic needs, human rights, and legal rights of AIDS-orphaned children.

The health sector in Zimbabwe recognised the importance of using well-established IEC channels to piggyback information for other critical matters like orphans and the situation of HIV affected persons. HIV/AIDS activities have been integrated in reproductive health and MCH projects, and health workers have been trained in counselling techniques. Operational guidelines also have been distributed recently (June 2000) by the Ministry of Health and Child Welfare, National Nutrition Unit, that outline infant feeding options for HIV-positive mothers. But there is no clear strategy for the integration of traditional healers in IEC prevention efforts; some districts have collaborated with the Department of Psychiatry to train traditional healers in infection control and counselling and to challenge some of their retrogressive cultural norms. There is also no clear strategy yet for dealing with burnout of service providers and community-based health workers.

The Ministry of Health and Quality of Life in Mauritius has issued a series of policies related to HIV/AIDS care and treatment which provide a substantial array of services, including:

- Free HIV testing irrespective of HIV status;
- Free access to medical care (i.e., prophylaxis and treatment of opportunistic infections, day care) irrespective of HIV status;
- A national programme providing VCT and anti-retroviral therapy (AZT) for all pregnant women attending antenatal clinics (and their children); the programme also provides artificial milk to babies born to HIV-positive mothers for a period of two years after birth. (It was estimated that a total of approximately 12 babies would be born to HIV-positive mothers during 2000-2001.)

The HIV epidemic is still 'concentrated' in Mauritius and has not yet spread to the general population. Yet it is also proving to be a challenge to reach those vulnerable (and marginalised) groups with these services, given their lower utilisation rates of antenatal care (ANC) and clinical/medical services. And it is a challenge to develop prevention messages for multi-ethnic and multi-religious target groups. The 2001-2005

National HIV/AIDS Strategic Plan aptly points out 'there is need to complete the situation analysis while strategies addressing the identified determinants are implemented.' Mauritius is well positioned to benefit from instituting 'best practices' developed in surrounding countries (with much higher HIV prevalence and incidence rates). In an effort to provide condoms, STI treatments, and community education campaigns to sex workers, pilot '100% condom use' projects have begun among sex workers. The Ministry of Health also collaborates with the National Agency for Treatment and Rehabilitation of Substance Abuse to achieve stated prevention goals among injecting drug users (e.g., 'there is a need to advocate for them (IDUs) having access to sterile syringes and needles').

A number of SADC countries are pilot-testing home- and community-based projects which are alternatives to hospital care. The Associated Press recently quoted South Africa's health minister as warning that the demand for treatment of AIDS-related conditions could overwhelm the country's health service system. A recent government study there concluded that effective control of tuberculosis is a national treatment priority.

Human Resources Sector

During this policy review, Zambia was identified as the only country with specific workplace programmes to educate civil servants and non-civil servants across the entire system of ministries and departments. Recognising that the epidemic is draining highly trained professional staff, the Office of the Vice President has developed a 2001 Workplan for provision of HIV/AIDS awareness workshops, training, and procurement/distribution of condoms. The Office's Department of Resettlement has a more circumspect programme consisting of 'provincial tours in HIV/AIDS,' training of staff, and the promotion of condoms so that they are locally available in shops serving resettled farming communities.

Labour and Employment Sector

Many labour sector policies include the realisation that HIV/AIDS prevention, control and support programmes can reach larger portions of the workforce through coordinated cross-organisational strategies. In Lesotho, the Ministry of Home Affairs' current (draft)

HIV/AIDS Strategic Action Plan includes objectives for at least 30% of that workforce to join government-supported medical and pension schemes by 2002 and provides counselling, food and transport support to HIV/AIDS-affected families of workers. In Tanzania, a Youth Development Policy was designed by the Ministry of Labour and Youth Development to link health promotion, family life education, and sexual health education among youth to a participatory development approach, given that youth make up 60% of the total workforce. This policy's guidelines (for multiple ministries) emphasise the importance of delivering non-discriminatory, accessible health services for youth in order to reduce transmission of HIV/AIDS and STIs.

Recognising that regional and national HIV policies should be synchronised, three national groups came together in Malawi in 1996 to develop an 'Industrial Relations Code of Practice on HIV/AIDS' that balances the need to provide workplace policy and business-savvy and legal guidance within the framework provided by national AIDS programme. It includes guidelines to eliminate discrimination, and a range of actions that companies can take to prevent HIV, including audits of employment and production areas where companies are susceptible to HIV/AIDS to inform human resource strategies and restructuring of benefits schemes. A taskforce was convened (in 2001) to review current laws impacting HIV/AIDS in the workplace (and to propose changes). A comprehensive policy for HIV/AIDS in the Workplace was issued in 2001, and workplace health committees were also established at various technical colleges and work institutions. The stated intent of the policy is to protect the rights of workers based on real or perceived HIV status; safeguard health and promote HIV prevention; promote 'enterprise-level,' community-based, regional, sectoral, national and international action (regulatory frameworks, collective agreements, plans of action); and promote cooperation. It is notable that the document contains specific applications (for public, private, and informal sectors), the scope of coverage in terms of people and principles, and rights and responsibilities — of government, of employers and their organisations, of workers and their organisations. There are also detailed guidelines for delivering prevention programmes in workplaces, training requirements, obligations regarding workplace testing and confidentiality, limiting risk to HIV exposure in the workplace, benefits and compensation for workers with HIV/AIDS, dismissal, grievance procedures, management and cost-benefit issues, and provisions for care and support.

The government of Malawi addressed the issue of translating national policy into corporation-specific policy and comprehensive HIV programming by testing a pilot project for development of one company's HIV/AIDS workplace policy (i.e., Shire Bus Lines). The development process for this 'enterprise-specific' policy reflected the national-level process: participants came from management, unions, the company's health department, human resources, and operational departments from all sections and regional offices. Participants were taken through an International Labour Organisation (ILO) checklist of policy development steps (formation of a committee, drafting a policy, monitoring/evaluating implementation of the policy). Participants were also briefed on guidelines contained in the draft ILO Code of Practice and SADC's Code of Conduct on the world of work. Relevant laws, including the Constitution, the Employment Act, the Labour Relations Act, Workers Compensation Act, the Occupational Health Safety and Welfare Act, the Wills and Inheritance Act, the Estate Duty Act, the Taxation Act, and so forth, were reviewed to ensure that they properly reflected HIV/AIDS issues. Best practices for prevention and care/support programmes implemented by other companies in Malawi and in the region were also reviewed.

Best practices included the collective bargaining agreement which resulted in the 'AIDS Agreement Between the National Union of Mineworkers and the Chamber of Mines of South Africa,' the HIV prevention programme implemented by the Portland Cement Company in Malawi, and the policy on care and support developed by ESCOM in Malawi. Similar to the national HIV/AIDS policy for the workplace, the Shire Bus Lines' policy describes responsibilities for different levels of employers/employees: for chief executive and executive managers, for line managers, employees, supervisors, shop stewards and for trade unions. A data collection system and a 'sickness and death database' are devised to enable the company to prepare realistic HIV/AIDS programme budgets. In order to expand medical services to include employees and their family members and to provide anti-retroviral therapy at subsidised cost, the decision was made to approach donors for financial, technical, material, and other resources. The company and the employees (through representatives) entered into a collective bargaining agreement in order to enforce the key aspects of the company's policy. This policy is unique in its provisions for checks and balances.

In South Africa, the national Inter-Departmental Committee (IDC) on HIV/AIDS facilitates the development of HIV/AIDS workplace policies in all national departments, setting minimum HIV/AIDS programme criteria and ensuring that they allocate funds to HIV/AIDS. These functions, which span national departments, ministries, and some trade unions, are typically the responsibility of human resources management. Six guiding principles are consistently emphasised throughout all national department workplace HIV/AIDS policies: 1) inclusion during policy development; 2) equality of rights and equitable benefits as other employees; 3) non-discrimination; 4) no mandatory testing or testing without consent; 5) confidentiality of HIV status; and 6) availability of counselling and social support for employees and those who work away from home. Yet the interpretation of these principles is uneven. Though most department policies emphasise that every effort will be made to optimise employees' health and productivity, the South Africa Department of Statistics' draft policy states that 'Stats SA cannot be expected to employ an individual who has AIDS…it is reasonable and fair to exclude people with AIDS or any other serious illness with such a shortened life expectancy when recruiting staff.' Whereas most Departmental policies expressly stipulate not using discriminatory practices or the HIV/AIDS status of an individual in consideration or provision of employment, the South Africa Revenue Services (draft) workplace policy requires that 'applicants with signs of advanced HIV disease or AIDS will be submitted for a full medical assessment and their fitness for work will be determined by the medical assessment.' This policy also singles out HIV-positive employees with opportunistic infections such as tuberculosis, pneumonia, and diarrhoea, directing them in particular to maintain proper hygienic precautions.

In addition to requiring employees to comply with the policies, some national department policies admonish (HIV-infected) employees that 'HIV/AIDS shall not be used as justification for non-performance of duties.' In contrast, a number of workplace policies make accommodations for HIV-infected employees in terms of duty station and work load (e.g., the South Africa Department of Water Affairs and Forestry's HIV/AIDS policy provides re-skilling programmes to prepare manual labour employees for the time when their illness will prevent such effort, and it provides for multi-skilling programmes to allow physically compromised employees to be rotated through a broad range of tasks).

Components of workplace programmes include distribution of South African Department-specific HIV/AIDS policies, IEC materials, and condoms; management practices for infected employees, including early retirement offers; provisions for liaison with local AIDS Service Organisations and the Inter-Departmental Committee on HIV/AIDS; and establishment of supportive, non-discriminating work environments with formal grievance procedures to register complaints. Only the South Africa Department of Public Enterprises and Department of Welfare's HIV/AIDS policies specify the importance of coordinating with the National Association of People Living with AIDS.

Due to common behavioural risk factors, more cost-effective and efficient disease prevention and control are possible when multi-level HIV, STI, and TB services are linked; yet sector-specific approaches to HIV/AIDS prevention do not typically include STI prevention and/or treatment components. Some exceptions exist, even within workplace-specific policies. The Lesotho Highlands Development Authority's Public Health Annual Plan, which focuses on providing health care services for construction workforces in compliance with Occupational Health Industrial Hygiene & Safety contract specifications, also includes objectives 'to strengthen preventive health services being provided to the communities' with activities to reduce STIs and HIV/AIDS. These include support for syndromic management of STIs and targeted HIV, STI, and alcohol/drug abuse prevention services for 'affected communities and the workforce.'

While guidelines for the implementation of HIV/AIDS programmes in employment are important, it is as important that there be consensus regarding intended results. Commendably, the workplace programmes of the South Africa Departments of Foreign Affairs and Justice include specific performance indicators, and all departments will continue to evaluate and adapt these draft HIV/AIDS policies via ongoing impact analyses. The Lesotho Highlands Development Authority's plan (cited above) also specifies joint target outputs with the Ministry of Health and Social Welfare and with NGO programmes in the work areas. And the Republic of Namibia's Ministry of Labour HIV/AIDS workplace guidelines delineate responsibility for monitoring and review of their implementation with the Labour Advisory Council in conjunction with the Ministry of Labour (thought specific indicators are not provided).

After three years of consultations and review of draft legal provisions by over 300 organisational representatives in Zimbabwe, Labour Relations Regulations were adopted by the National Tripartite Committee in 1998. These regulations are the product of the Intersectoral Committee on AIDS and Employment, chaired by the Ministry of Public Service, Labour and Social Welfare, and involving the Employers' Confederation of Zimbabwe, the Zimbabwe AIDS Coordination Programme, and NGOs with expertise on HIV/AIDS. The law establishes the rights and responsibilities of both employers and employees with regards to the prevention and management of HIV/AIDS and its employment consequences. It specifically bars employers from requiring HIV testing as a precondition to employment, termination, or benefit eligibility. The National Orphan Care Policy establishes a six-tier safety net system of orphan care (i.e., orphans first remain in biological nuclear families; when both parents die, the extended family assumes care; then the community designates guardian(s); then children may be placed in formal foster care; then children may be placed for adoption; and orphans may be institutionalised as a last resort). The Department of Social Welfare promotes informal foster care of orphans through the traditional care systems such as community or extended family care and provides triage to free medical treatment or payment of school fees.

In its 2001 workplan, the Zambian Ministry of Labour and Social Security declared AIDS a 'national disaster' threatening productivity of factories, farms, plantations, mines and other enterprises. While the government has no laws specifically covering employment-related AIDS issues such as HIV screening and pensions for HIV-positive employees, it endorses the policies recommended by WHO, the ILO, and the SADC code on HIV/AIDS in the workplace.

Increased mortality will increase demand for provision of compassionate leave, which becomes a labour availability issue for employers. Yet none of the policies included compassionate leave benefits. And though many policies carried directives that every employer promote risk-reducing measures and referrals to counselling facilities, none described methods for monitoring compliance. Unfortunately, the greatest 'assumption' of many of these labour sector workplans is that 'adequate financial resources will be available', so it is difficult to gauge how extensively the planned activities are actually being implemented.

Minerals and Energy Sector

In some countries within the SADC region, workplace HIV/AIDS prevention programmes are being extended to affected communities and some employers are establishing infrastructure for care and support of infected and affected workers. For instance, the Republic of Namibia's Ministry of Mines and Energy, in partnership with unions and relevant private corporations, is targeting not only mineworker employees but also families and 'relevant communities' for HIV/AIDS prevention, condom distribution, and care and support programmes.

In Zambia, the Ministry of Energy and Water Development has recognised the loss of manpower, loss of production hours due to attendance of funerals, and costs of recruitment and retraining incurred as high HIV/AIDS mortality rates are experienced among its highly mobile staff. Its 2001 workplan includes training designated 'HIV/AIDS focal point persons' and health committees at headquarters and nine provincial offices; they will in turn conduct workshops at which (male and female) condoms are distributed, establish counselling centres, and provide support through peer education. It is not apparent what levels of condom coverage are to be achieved, and a major 'foreseeable problem' is the non-availability of sufficient funds for these programmes. Most of the programme outputs are described in terms of increased awareness among staff; this is in contrast to the enormous opportunity for step-wise risk reduction which exists, given that approximately 20% of the adult population in Zambia is currently infected and that there are encouraging signs of declines in HIV prevalence (among 15-19 year old women) due to behaviour change. According to the 1996 Demographic and Health Surveys (DHS), over 99% of the population was aware of the disease syndrome, indicating that programmes should now be focused on attitudinal change, risk reduction, and care and support at this phase in the epidemic. Mechanisms for sharing successful behaviour change strategies across sectors might strengthen and reinforce these workplace-specific activities.

Tourism Sector

The Environment and Tourism sector of the Republic of Namibia is providing prevention programming and condom distribution at all ports of entry and exit points and tourism

facilities. The Ministry of Tourism is partnering with the Hospitality Association of Namibia in this endeavour, targeting HIV-related activities to local and international tourists, ministry employees, and all Namibian Foreign Missions.

A more limited, IEC-specific prevention programme is planned by the Ministry of Tourism in Zambia. The 2001 plan targets hotel managers, tour guides, tour operators and travel agents, wildlife police officers and their spouses, and tourists, and provides for peer education and counselling efforts as well as dissemination of brochures and videos. But only 10% of the needed funds to carry out the plan are available, and intended results relative to risk-reduction are not clear other than in terms of number of workshops to be held.

Trade and Industry Sector

Through collaborative cross-sector approaches enhancing private-public partnerships, legitimacy for HIV/AIDS programmes is strengthened, stigma is counteracted, and behaviour change messages are reinforced. In Namibia, the formal and informal business sectors partnered with the Ministry of Trade and Industry to establish sector obligations for preventing HIV/AIDS throughout business communities and to ensure that company policies are developed in alignment with the National Code on HIV/AIDS in employment. As large a target population as 'all employees within the business communities and their beneficiaries' ensures that multiple communication channels will be used for prevention programming and that infrastructure for care and support will be built beyond the public sector.

In Zambia, the Ministry of Commerce, Trade and Industry released a workplace-specific HIV/AIDS workplan for 2001 in response to staffing and performance loss among HIV-infected/affected employees. The programme focus is development of peer educators who will also become home care advisors. The scope of this programme is broad, including the commercial and industrial sector business communities that most often interact with the ministry. While condom procurement and distribution is one objective of this programme, it is earmarked for only 2% of the budget, and it is not clear whether condoms will be made available for free or whether there are provisions that maintain employee confidentiality.

Transport and Works Sector

Wide-reaching condom distribution is made possible through dissemination plans that cross sectors. In Lesotho, the Ministry of Works, Department of Rural Roads plans to supply free condoms to employees and the Ministry of Home Affairs is planning to provide both male and female condoms dispensers. In Namibia, ministries' and unions' respective works, transport, and communication companies will ensure condom social marketing and care and support services.

In Zambia, the Ministry of Works and Supply has established a workplace-specific HIV/AIDS workplan for 2001 (for workers and their families) that revolves around the formation of a Health Committee, establishment of workplace condom distribution centres, and a travelling theatre group to 'sensitise workers…on the messages of the HIV/AIDS campaigns.' It is noteworthy that an impact assessment is planned to identify behavioural objectives for these campaigns, but it is not clear that provisions for care and support will be included.

Uniformed Services and Police Sector

The Department of Correctional Services in South Africa has provided a dynamic programme of AIDS education and counselling since 1996. Developed as a team effort between staff from Psychological Services, Welfare Services, and Staff Services, the programme includes awareness and education components, and explicit discussions about high-risk behaviours 'specifically with reference to sexual activities and tattooing' as well as 'the exchanging of needles and syringes for use in administering intravenous drugs.'

Care and treatment issues are addressed in some detail in the South Africa Department of Correctional Services' management strategy for AIDS in prisons. This directive provides for the establishment of STI clinics at all prison hospitals and for distribution of free condoms supplied by the Department of Health. Universal precautions and protective clothing are available for both nursing staff and prisoners assisting on wards in prisons and prison hospitals. Detailed requirements are described for cleaning linen and contaminated instruments, disposing needles and syringes, and treatment in the

case of needle stick injuries. Eligibility for AZT is available only through a referral chain from provincial hospitals to academic hospitals; recommendations for treatment regimens are the result of consultations between provincial hospital AIDS specialists and District Surgeons. In some cases, prisoners with AIDS can be placed on parole and required to regularly visit AIDS Information and Training Centres.

The Safety and Security Sectoral Bargaining Council's HIV/AIDS policy offers immediate access to *free* anti-retroviral medication (as well as adequate HIV test counselling and support) to any employee of the South Africa Police Services (SAPS) following an injury on duty. It stipulates that 'the cost of care and counselling should in the first instance be re-imbursed or borne by SAPS.'

Over a million ($U.S.) budget is attached to a proposed, comprehensive 5-year HIV/AIDS prevention, care, and support programme drafted by the Zambia Ministry of Defence/Zambia Defence Forces. Proposed activities include condom distribution, provision of home-based care, and training of psychosocial counsellors, peer educators, and caregivers for an array of target groups, including youth in the military, women, military dependents and civilian populations. Programme plans are quite progressive in that they include eventual procurement of AZT and integration of MTCT services in existing MCH programmes. The extent of ministry support is not entirely clear, however, given that only U.S. $18,000 is currently available in funding.

Faith-based Responses

The responses of faith-based organisations and religious groups to issues of human rights, destigmatisation of HIV disease, and provision of care and support at the community level have been well documented. Yet the challenge remains to link and integrate their decentralised activities with overall strategic plans on the national level.

Examples of increased involvement of religious institutions in HIV/AIDS strategic planning and service delivery do exist, however. A representative of the Council of Churches in Namibia serves as a member of the National Multi-sectoral AIDS Coordination Committee. The four main churches in Lesotho have been instrumental in HIV prevention and behaviour change activities as well as home-based and orphan care

service delivery. Tanzania's Medium Term Plan III designates the Christian Council and the Muslim Council of Tanzania as resources for implementing behaviour change strategies among highly mobile populations. And its multi-sectoral guidelines treat community-based spiritual care as a component of policy issues focused on holistic care for PLWHA.

Private Sector Responses

In Lesotho, the private sector, including the largest chain store, have mounted fundraising campaigns and income-generating activities to support HIV/AIDS prevention and control initiatives undertaken by the Lesotho Red Cross Society and an association of PLWHA. Additionally, an insurance broker in Lesotho has provided management training for HIV/AIDS community support groups and financed some of their projects.

In South Africa, Mammoth Insurance, one of the largest companies in the insurance industry, has been active in advocating for policy and legislative reform in the insurance industry in favour of PLWHA and has provided free guidance in the preparation of wills and trusts. In Zimbabwe, some employers have committed to workplace-based IEC activities and provision of on site medical facilities. There is a growing employer interest in providing and/or financing home-based care activities if NGOs can be credible, reliable, and accountable service providers, and these types of arrangements are just now being forged.

V. Conclusions

Comprehensive National Policies

The HIV/AIDS epidemic has reached alarming levels throughout the SADC region. All countries have organised some kind of response to this problem. Several countries have developed comprehensive national HIV/AIDS policies. These include Botswana, the Democratic Republic of Congo, Lesotho, Swaziland, Tanzania and Zimbabwe. Among those that have not developed national policies, several, including Malawi, South Africa and Zambia, are developing or considering developing such policies. Zambia just developed a national policy in 2002. A national policy is not necessarily required since specific policies can be set in plans and legislation. Zambia, for example, mounted a vigorous AIDS programme without a comprehensive policy, but with annual reviews of specific policies and laws and the formulation of specific policies when required. However, the HIV/AIDS epidemic affects so many aspects of national, community, family and personal life that the lack of a comprehensive policy becomes more serious as the epidemic develops. A national policy also sets the framework within which sector policies can be developed.

Recommendation: Each country in the region should be encouraged to develop a comprehensive national HIV/AIDS policy.

New efforts to develop comprehensive national policies can benefit from the experience of countries that have already developed such policies. The existing policies provide good examples of the issues that need to be addressed and approaches to these issues. The process of policy development is also important. The Zimbabwe policy formulation process is a particularly good example of a participatory approach that provided great scope for involvement by all sectors of society and produced a consensus policy that was readily adopted and implemented.

National Strategic Plans

Almost all countries in the region now have HIV/AIDS strategic plans. These plans are required for a variety of purposes: to set goals and objectives for an expanded response, to describe the strategy to achieve those goals, and to estimate the funding required.

Strategic plans with budgets are now also required for applications for additional funding to the GFATM. While most of the strategic plans in the region do an excellent job of describing goals, objectives and strategies, there is wide variation in the approaches used to cost the plans. Plans that do not have well developed, reasonable budgets are less likely to be favourably received by donors and may be at a disadvantage when applications to the GFATM are reviewed.

Recommendation: SADC should work with UNAIDS to develop and disseminate sound costing approaches and ensure that national programmes have the training and assistance they need to implement these approaches.

Multi-sectoral Approaches

All countries in the region have adopted multi-sectoral approaches to HIV/AIDS prevention and care. However, these approaches vary considerably from one country to the next. In some cases, ministries other than health are encouraged to develop their own AIDS control programmes with specific staff assigned full time to AIDS, while in others ministry liaisons are assigned to coordinate activities with the Ministry of Health. Many countries have organised a National AIDS Council, located in the Office of the President. These councils are charged with organising the multi-sectoral response. In most countries, these councils are quite new and still attempting to discover the best way to coordinate the expanded response. To some people the term 'multi-sectoral approach' means involving all sectors of government, while to others it is a broader term meaning the involvement of all aspects of civil society. As countries struggle to implement these new approaches, they can learn much from each other's efforts.

Recommendation: SADC should help to promote information sharing among countries on the various approaches to organising and implementing a multi-sectoral response and on the successes and failures of such a response. This could be accomplished through comparative reports, special regional meetings, observational travel and SADC forums at international and African AIDS conferences.

Sector Initiatives

Health is the lead sector in the response to HIV/AIDS in every country in the region. Most counties involve other sectors as well. The Education sector is the involved in almost every country. The Labour and Employment sectors and the Youth/Culture/Information/Sports sector are the next most frequently involved sectors. Next come Agriculture, Tourism, Transport and Works and Uniformed Services. Only about half the countries have active programmes involving Finance and Economic Development, Minerals and Energy, or Trade and Industry. Other sectors are even less involved.

The biggest question around sector initiatives is not so much which sectors are formally involved in the AIDS programme, but what they are doing. In some cases, ministry participation is limited to having an AIDS policy for the ministry employees while in others, the ministry is actively involved in implementing programmes to address HIV/AIDS for its constituencies (e.g., school children, prisoners, military personnel, truck drivers). Generally, within SADC only the Education and Health ministries have detailed implementation strategies to serve their constituents.

Recommendation: SADC could facilitate greater sector involvement in HIV/AIDS programmes by promoting dissemination and discussion of concrete examples of successful sector programmes both inside and outside the region.

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